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THE CHRONIC
DRUNKENNESS OFFENDER

CHAPTER XVIII

TREATMENT FACILITIES, EXISTING AND PROPOSED FOR THE CHRONIC DRUNKENNESS OFFENDER

Authors: Gustave Oki
Sylvia Lambert

Research Assistant:
Nils Kuusisto

Project Director:
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Substudy 499

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FOREWORD

The homeless, indigent alcoholic is a frustrating challenge to a society committed to alleviating what it defines as "social problems." As early as 1891, a commission of enquiry in Ontario called the existing system of dealing with drunkenness offenders "an utter failure," and went on to say:

> The imposition again and again of a paltry fine with the alternative of a few days, or a few weeks imprisonment, has no serious effect either reformatory or deterrent, and a cry against the continuance of this absurd system has arisen in every country in which drunkenness is prevalent.*

The commission recommended "industrial reformatories for inebriates," such an institution to be "chiefly an hospital having for its main object the reclamation of drunkards and the cure of inebriety." Men who had three convictions in two years were to be committed by the courts for "long periods."

Nothing came of these recommendations but the Ontario Legislature took steps that presaged the current movement to "decriminalize" public intoxication. The Municipal Act was amended in 1892 to allow public drunkenness offenders to be released without trial on the occasion of their first two arrests. In 1896 the Act was further amended to allow inebriates to be released without trial any number of times. If any municipalities took advantage of this provision at the time, it had no lasting effect. The system of repeated arrest and incarceration continued until the present day to be the dominant means of dealing with homeless inebriates in Ontario.

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* Report of the Commissioners to Enquire into the Prison and Reformatory System of Ontario, 1891. (Toronto: Legislative Assembly, 1891), p.106.

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The commissioners were ahead of their time. The "cry against the continuance of this absurd system" did not become strong enough to bring action on a significant scale until the last couple of decades. The change has come with a growing faith in modes of manipulation that can be labelled "treatment" or "rehabilitation" and the extension of this faith to an increasing range of deviant behaviours. More specifically, the movement to deal differently with homeless alcoholics has gained impetus both from the spread of the conception that alcoholism is an "illness" (with all its attendant ambiguities) and the growing reaction against imprisonment, especially for petty offenders. Given the resources of an affluent, and increasingly professionalized, society, the result has been the proliferation of new programs for chronic drunkenness and an even greater range of proposals.

The study that follows is a critical survey of the main types of programs and proposals that have been reported in the literature in recent years.

The report is timely because the current tendency to "decriminalize" public intoxication has lent urgency to the quest for alternative ways of dealing with homeless inebriates on a large scale. Some legislatures have done away with public drunkenness as a punishable offence. In other jurisdictions, some courts have anticipated the trend by substituting suspended sentences for imprisonment, and enforcement on the part of the police has become less rigorous. If we project the trend, it seems likely that imprisonment for simple intoxication will join the detritus of crime and punishment. But what is to take its place?

The revolving door - whatever its undesirable consequences - has performed a caretaking function for a large number of homeless

drinkers. Being picked up by the police, and awaiting trial in the lock-up, did provide the homeless drinker with protection and some chance to dry out. And where prison sentences have been common, the extended period of recuperation and the spacing of sprees have served to lessen physical deterioration (see The Chronic Drunkenness Offender, Chapter 12, "Physical Health").

The reader will note that a majority of the programs discussed here have been supplementary or ancillary to the revolving door. Their size, scope, and sometimes organizational locus, have been based on the premise that a majority of homeless inebriates will be handled by the police, courts, and prisons. They have been rescue operations for a few rather than models for a comprehensive system of ostensibly non-punitive social control that would replace the revolving door. The present report may be of help in deciding whether some combination of the programs that have been tried could be fitted together to form a comprehensive system, given the necessary degree of centralized control and subsidization.

This report is not intended to be an exhaustive inventory of programs or proposals. Our concern has been to uncover the main types of programs without seeking out all the concrete examples. Most of the information has been derived from such secondary sources as periodicals in the alcoholism field and published reports of conferences, committees, and projects. The understandable desire to receive recognition for worthy endeavours seems to ensure that most programs or proposals that are innovative or significant in scope came to light in the literature. The first collection of information was carried out by Mr. Nils Kuusisto in the early 1960's. The other authors recently searched the literature for developments since that time.

The report is also not intended to be an account of the history of specific programs. It is concerned with their nature rather than their fate. Some of the programs are known to have become

defunct and some to be still functioning; but in many instances we do not know whether or how long they have lasted. In order to be consistent, the authors have used the present tense in describing all the programs. A study of the exigencies that have affected the growth and decline of various programs would be useful to planners, but it would require much more intensive research.

The study also incorporates some opinions about treatment derived from interviews and mailed questionnaires in Ontario. The views of the chronic drunkenness offenders themselves were gathered in the course of long interviews with a sample of 235 in Toronto's Don Jail in 1960-61. Police chiefs and magistrates (whose title has since been changed to provincial judge) throughout Ontario were sent short mailed questionnaires in 1963 which asked, among other things, for their suggestions regarding other methods of dealing with chronic drunkenness offenders. Since the configuration of opinions may have changed since then, the authors report on the range of opinions rather than specific frequencies.

As the reader will probably conclude for himself, a report on programs for homeless alcoholics is likely to tell us more about auspices, organizations, and broad aspirations, than about the content. This reflects problems endemic to the field. It is easier to create and describe a clinic, a residential treatment centre, a halfway house, or whatever, than it is to plan in specific terms what is to be done with the clientele or to explain afterwards what they have experienced. "Treatment" and "rehabilitation" obviously are warmly evocative but vague terms, applied in practice to a diversity of concrete behaviours and contrived situations. Additional vagueness about the content of many programs for chronic drunkenness offenders stems from genuine bewilderment about how to deal with them. Their seeming lack of motivation and the many objective problems in their life-situations mean that the treatment modalities developed in relation to alcoholics with resources appear to be inadequate or

inappropriate. Counselling and the various "talking" therapies, for example, do not overcome the practical obstacles to securing jobs, homes, and social ties. What appears to be needed are imaginative and experimental programs that go beyond the methods already legitimated by the faith of practitioners.

P. J. G.

September, 1972.

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CHAPTER XVIII

TREATMENT FACILITIES, EXISTING AND PROPOSED, FOR THE CHRONIC DRUNKENNESS OFFENDER

The purpose of this chapter is to find out through a search of the literature what kinds of institutions have been available to chronic drunkenness offenders for treatment and rehabilitation; also to what extent such institutions have been used by them and how effective they appear to have been. In addition we have reviewed recommendations made over the past few decades for treating the C.D.O. Since most of these proposals are based on research or actual experience in the field, we would hope to find suggestions that could be applied to the chronic drunkenness offender in Ontario. Finally, we have included data collected from three first-hand sources to evaluate programs and approaches dealing with our own study population.

The various styles of treatment and rehabilitation facilities have been gathered under six headings. With respect to the first five, the term "treatment" refers to activities directed towards the chronic, long-term manifestations of problem drinking. The last section has been added since the original review of the literature was made, and covers a specific type of service that deals with the acute or emergency forms of problem drinking but does not cover the typically medical care given in emergency wards of general hospitals.

The first two programs described, Custodial Institutions and Court Supervised Programs, are carried out under the provisions of various criminal statutes and other related legislation and involve the arrest and, in the former case, the commitment of the offender. Two others, Skid Row Institutions and Halfway Houses, provide facilities which may be publicly or privately sponsored and which are open to the C.D.O.s while they are

'outside' - i.e. not in jail. The fifth group is Mental Hospitals, to which the C.D.O. can gain admittance through civil commitment. The last is Detoxication Centres, where entrance may be voluntary "off the street"; or it may be used as a voluntary alternative to arrest, or involve actual arrest of the person found drunk in public. The last two cases usually necessitate the cooperation of the police to escort the person to the Centre instead of to the drunk tank.

General hospitals, clinics and private sanatoria have been omitted, since they either do not typically treat alcoholism per se, or could not be considered available to the C.D.O.[1]

Narrowing the field down to Ontario, we have obtained the opinions of three groups of persons who are intimately concerned with the validity and usefulness of facilities open to C.D.O.s in this province. The three groups are: Ontario Magistrates, Chief Constables in Ontario, and our sample group of incarcerated chronic drunkenness offenders.[2] The first two sources confined their opinions to those custodial institutions with which they had had experience, but were able to offer some suggestions for alternative treatment and care of these men. The opinions of the C.D.O.s were sought concerning four separate facilities in the Toronto area with which they might have had contact. They were also asked if they had any suggestions for treatment.

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[1] Since our original review of the literature several general hospitals in the U.S.A. have established treatment programs for deteriorated alcoholics, independently or in conjunction with other agencies. See, for instance, "Changing Attitudes on Alcoholism Affect General Hospitals," Currents in Hospital Administration, vol.11, April 1967.

[2] The term "chronic drunkenness offender" refers generally to a person who has been repeatedly convicted for the offence of being drunk in public. To select our Toronto sample we defined the C.D.O. as a person with three drunkenness convictions in the past 12 months, who was currently incarcerated for the same offence.

That the treatment facilities available to them have not necessarily been either useful to or used by the C.D.O.s in appreciable numbers becomes evident. The reasons are apparent in the following review of existing facilities, which has been made from a search of the available literature and from reports received in response to a mailed inquiry sent to the authorities in charge of some of the programs. Many of the facilities are not specific to the needs of the C.D.O. and therefore treatment is only partial or irrelevant. Some offer programs oriented chiefly to the C.D.O., but they are probably of too short duration to be effective. Some appear to have good potential if coordinated appropriately with other services in the community - presuming such services exist.

The literature makes frequent mention of the C.D.O.'s lack of motivation toward treatment. There is little mention of the pessimism of planners and supervisors, which infiltrates their suggestions and has a part in shaping their programs. Very frequently when a program which has not been set up for the true or hard-core C.D.O. fails with such a client, the pessimism is considered justified and the C.D.O. is written off as incurable.

It is becoming less and less easy for sociologists, magistrates, social workers, and humanitarians in the general public, to support the process by which a chronic drunk is jailed repeatedly for no other reason than being drunk in public and because there is nothing else to do with him. It could become all too easy in a combined excess of relief, pessimism and beneficence to settle for a program of indefinite, vegetative custody.

CUSTODIAL INSTITUTIONS

Custodial institutions for the treatment of drunkenness offenders are defined for the purposes of this discussion as institutions which accept persons incarcerated for drunkenness or any other offence where the person has a drinking problem, for treatment within a prison or reformatory, or in a custodial institution especially designated for this purpose. Such

institutions, like the court supervised systems, tend to deal with true chronic drunkenness offenders in considerable numbers, the difference being that in the former systems the men must serve their sentence in custody while under treatment. The orientation is away from the punishment and toward the rehabilitation approach. In general, these programs have arisen from "the conviction that the penal commitment of alcoholics is a failure" (15,p.346) and because chronic drunkenness offenders "have become a problem and expense to the community" (9, p.475).

Humanitarian reasons probably underlie most of these programs, but economic and other practical considerations are usually the explicitly stated reasons deemed necessary to justify their actions.

The total number of custodial institutions disclosed by the survey is 27 . The programs vary in intensity from a one-hour lecture per month within a prison, to a total institution, set up specifically for repeated offenders or habitual drunkards. Many of the programs are voluntary within the prison system and therefore reach only the better motivated offenders or those who feel that by volunteering they can do relatively "easy time."

The number of recommendations in the literature which suggest custodial institutions for retaining alcoholics is 27. However, many writers, recognizing the need for new legislation, suggest custodial institutions for chronic drunkenness offenders and other alcoholics, either as a first step or as an interim step toward dealing with the whole problem. Others see them as one part of a multi-aspect program. The general consensus is that jail is not the place for alcoholics or chronic drunkenness offenders; that unless some other crime has been committed in conjunction with excessive alcohol consumption, the person should not be considered a criminal, and that the problem is a public health rather than a legal one. However, insofar as it is necessary to work within the present legal system where drunks are jailed, a type of treatment institution should be set up within the penal system to deal with these persons.

A few writers feel that as it is only within the jail setting that chronic drunks can be reached en masse, that is where treatment systems should be located. Other writers suggest that different types of alcoholics require services that vary in kind or degree: for example, some react best to voluntary treatment; for others such as the C.D.O., compulsory treatment can be effective and is necessary (21,56). Some alcoholics need a protective environment (47,48). It is suggested by Glinker (23)that deteriorated alcoholics need rehabilitative custodial institutions.

Most of the authors of these proposals agree, by implication, with John Murtagh's view that the penal approach to the Skid Row derelict is expensive, profitless, and inhumane (38). Even those who feel that compulsory treatment in a custodial setting is neccessary, suggest that the inmate should be treated not as a criminal but as a patient (56).

Auspices - Existing

Custodial treatment programs have been initiated at various levels of government and function under a variety of departments. Thirteen of the 27 examined are controlled and financed by state or provincial governments (2,3,4,7,8,10,17,24,25,30,37,34,39) through such bodies as the Department of Public Health, (Division of Alcoholic Rehabilitation)(3), the Commission on Alcoholism (4), the Board of Corrections (10), the Prison Department (24), the Department of Corrections together with a provincial alcoholism foundation (2), and the Department of Reform Institutions (34)(now the Department of Correctional Services). Although it is not specifically stated, it seems reasonable to infer from the descriptions, that either the Department of Welfare or the Department of Corrections is responsible for the remainder.

Five (14,19,51,55,59) are under county jurisdiction; in one case (14) the Department of Public Welfare. Five are operated at the municipal level by a city department of welfare(11), a city jail (44), a police department (52), and one (15) is under the jurisdiction of the municipal court and an Adult Guidance Centre.

One program was initiated by the city jail (51), one by the police department (52), and one by a prison warden (16) In the first instance, the Los Angeles City Jail started the program and financed it, but the Police Department is responsible for operating it. The Seattle program (52) is now defunct for lack of funds. In Louisianna (16) one year's financing came from a Louisianna State Commission on Alcoholism, and many of the workers were volunteers, including university students. In one program (24) the funds came from the prison system but they are minimal and the members of A.A. who conduct the program pay their own expenses.

Five of the programs (5,10,16,19,24) are based primarily on the A.A. philosophy and operate in cooperation with local A.A. groups. Five others specify that they incorporate A.A. in their treatment programs (15,17,30,44,59). Two work in cooperation with provincial alcoholism foundations (2,17), one with a hospital (55) and one with a community service group (15).

In general, the more substantial programs - those with prison farms, specialized institutions and professional staff - have been inaugurated and are being operated by departments and officials who have, from their experience, seen the need to attempt some form of rehabilitation.

Auspices - Proposed

The various proposals which suggest custodial treatment do not come to grips with the problem of administrative responsibility for such establishments. Only one (33) recommends that they be administered by the Health Department of the State rather than the Correctional Department. However, it is understood that the restraining powers necessary to custodial treatment require the sanction of the law and usually the supervision of agents of the law or persons responsible to it.

Where the form of administrative structure is specified, it usually requires that the court dealing with the offender be coordinated in its use of the law with treatment facilities, by a pre-trial screening facility (20,26,33,35,45,48,49,60).

The pre-trial clinic staff would advise the judge as to their opinion of the appropriate sentence and referral for the individual offender. Three other proposals include a screening aspect to their program but do not indicate what relationship, if any, this would have to the court (1,23,46).

Although the particular administrative arrangement does not appear to be a concern of the author in most cases, we can assume from the nature of the institution that he intends it to be undertaken and supported by some level of government. This is more directly evident in the three cases that are reports of state governmental commissions (1,4,35) and the one (49) that is the representation of a welfare council in a municipal government (New York City). Another (60), authored by a community association on alcoholism, is directed toward the local county government.

One proposal (56) does concern itself with the administrative structure. It is the Finnish context and envisages a unitary governmental structure to guide and coordinate the functioning of subsidiary facilities such as homes, asylums and work homes for problem drinkers.

Duration - Existing

With the exception of the two European ones (8,57) these programs appear to be of the post-World War II era. The two programs in Houston jails (5,61) were announced in June 1964, but do not appear to be sufficiently unique to be worth following up. The Seattle Police Department Rehabilitation Project, specifically designed for chronic drunkenness offenders, was dropped in 1961 because of a budgetary consideration, despite the enthusiastic support of the police department. As to the rest, there is no evidence in the literature of their having been terminated.

In two of these institutions the program appears to be in process of change (2,17). The Belmont Rehabilitation Centre in Alberta (17) is being put under the Department of Health of the provincial government and is being coordinated with other facilities in an attempt to revive the aspirations of the original program.

Oakalla Prison program (2) has been under criticism for a number of years by the Alcoholism Foundation of British Columbia and new facilities are being constructed that may affect their program.

Dates and Background of Proposals

The majority of proposals originated in the 1950's. Four are from the 1940's and 4 from the 1960's. The oldest (29) of the modern era originated in Germany in 1926 - a year or less before the establishment of the abstinence sanatoria like Ellikon Asylum.[3] This proposal for special custodial institutions was carried out, except that inmates entered voluntarily. Other foreign proposals are two (7,56) from Finnish and Danish sources respectively. Both envision or assume a national organization, presumably because of the feasibility of such in smaller countries, and compulsory custodial treatment. Another international proposal comes from the Expert Committee on Mental Health of the World Health Organization (58). This recommends that alcoholics who commit crimes, or who are considered dangerous to themselves or others, should be sentenced to obligatory treatment while under restraint. The remainder of the proposals can be classified by their backgrounds into three groups:

1. Proposals contained in reports of governmental commissions or community groups, whose task is generally to formulate recommendations for a system to deal with alcohol problems (amongst them, the problem of the chronic drunkenness offender) (1,4,20,23,35,49, 60). Two of these (23,60) were from community alcoholism committees; three (1,4,35) are for state governments in the United States (appointed by and reporting to these governments); and two (20,49) are the reports of committees to the municipal government of Atlanta and New York respectively. These are all aimed at governmental action on municipal, state (provincial) or a national level except one (23), which is aimed at a general hospital-centred program.

2. Proposals coming from specialists in various fields which impinge upon the problem, e.g. the legal area and mental hospitals (22,26,29,31,36,40,50,53). Four come from persons with backgrounds related to the treatment of alcohol problems

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[3] See page 71.

in mental hospitals (22,31,40,53). These are slightly off the topic in that they focus primarily on chronic alcoholism, which is not by any means the chief problem of the chronic drunkenness offender. They do, however, deal with comparable problems of recidivism among this population. Of the others, two (26,50) are concerned respectively with the legal and penal problems in dealing with C.D.O.s, and the idea that there should be specialized institutions for chronic alcoholics.

3. Proposals from specialists directly in the field of alcohol problems and particularly the problem of treating C.D.O.s (6,21,33,45,46,47,56,62). The oldest (33) comes from the Executive Director of the Osborne Association in 1940, and deals with penal and correctional aspects. All the other proposals are papers[and a book(46)] written by persons associated with research on treatment facilities (21,62) or research on alcohol problems (6,45, 47), particularly on the chronic drunkenness offender.

Admission Processes - Existing

All persons convicted for breaches of the law, whether they are chronic drunkenness offenders or persons charged with other offences but who manifest a drinking problem, are eligible for the custodial treatment programs. Thereafter, selection varies, the main difference being whether the programs are compulsory or voluntary.

Eleven programs automatically include all chronic drunkenness offenders (3,4,8,11,14,19,25,30,39,41,57) and in one program (19) the law makes first offenders eligible. They involve sentences to specialized facilities; in one case to a jail clinic (14). In the Danish system (25) the law covers all chronic criminal offenders, referring those with alcohol problems to a custodial asylum for intensive treatment. In three cases (8,41,57) conviction for presumably all charges involving drunkenness or alcoholism (not rigorously defined), on the theory of prevention of social damage, makes the individual liable to

compulsory institutionalization. In Sweden, commitment is ordered by the Stockholm Temperance Board.

Fourteen require that the prisoner volunteer for treatment. Of these, 6 attempt to determine a good prognosis for treatment through a screening process by the clinic staff (34,37,44,51,59,61); in one (17) the screening is done by a prison selection committee and in another (52) by a police officer. Another (16), which is voluntary without screening, commits the person to 90 days' sentence with earlier release at the discretion of the staff. In one voluntary program (15) persons are recruited from several sources. Some are referred by the judge without screening; others are sent after an interview by the Deputy Attorney-General of the State, and others are screened while in the 'drunk tank' by a psychiatrist. (In this case, circumstances are weighted against frivolous volunteering, since the alternative is usually dismissal.) One program (55) leaves it to the discretion of the court to commit the chronic drunkenness offender to an in-patient treatment facility in a local hospital for 60 days if he threatens to do damage to himself or others; in another, further screening after commitment by the judge is done by the clinic staff.

Admission Processes - Proposed

About 3 out of 4 (19 of the 26) proposals which suggest custodial institutions for chronic drunkenness offenders favour compulsory treatment. Three others (7,45,50) appear to assume compulsory institutionalization in their proposals. The 4 remaining proposals (23,31,36,40) do not specify or appear to assume a form of compulsory admission but might assume civil commitment as in mental diseases because of their emphasis on alcoholism having a psyochopathic basis, or because of the incapacity of deteriorated cases (36).

Nine of these proposals suggest compulsory institutionalization as part of multi-aspect programs (1,20,22,26,35, 46,49,56,62) or only for certain offenders (the 'incurables') who are considered inappropriate for referral to other rehabilitation services (1) or the severe cases who are considered to need institutional care (22). 'Severe alcoholism,' 'resistant alcoholics' and 'incurables' are all generally seen as requiring compulsory institutionalization for their own protection and the protection of others - and because that is all we can suggest for them. In seven of these the source of referral would be the Court, which would have alternative facilities at its disposal and would act on the advice of a screening staff (1,20,26,35,46, 49,62).

The remaining proposals do not specify facilities other than a custodial institution as part of the proposed programs. Two proposals (4,47) suggest that the custodial facilities should accommodate both voluntary and compulsory committals. The term 'voluntary' is not defined, but in one (47) it appears that volunteers would be taken in off the street and in the other the Court might ask the individual to volunteer, the alternative being jail.

Six of these proposals (4,6,22,53,58,62) appear to mean by 'compulsory' treatment, that civil commitment could be carried out by the court in cases of chronic drunkenness rather than a variation of procedure under the criminal law.

In none of these proposals, with the possible exception of the one case mentioned above (4), is it advised to leave the choice of compulsory treatment up to the offender.

Screening processes are usually proposed as necessary to a complex program with a number of alternatives open for the disposition of the offender (20,26,35,47,49,50,60). In such cases the purpose of the screening is to determine what the individual is most in need of and which facility or agency could best serve him. Some proposals (1,6,20,21,33,35,45,58,62)

would screen the individual only by his criminal record to determine if he is a C.D.O. Only one (35) specifies a number of offences as the qualification of the offender as a C.D.O.: being arrested for drunkenness 8 times in the previous 18 months.

The proposed systems in Georgia and Maryland illustrate two extreme examples of how admission processes would meet the dilemma involved in treating this kind of offender (4, 35). Georgia would accept virtually all such offenders. All drunkenness offenders and volunteering problem drinkers would be sent to the custodial farm facility (there is no mention of a screening process or of any treatment program). In the proposed Maryland system, pre-trial screening (using the Mindlin Scale)[4] would separate chronic drunkenness offenders for probational out-patient treatment or custodial in-patient treatment. The Maryland system is an example of a fairly refined way of determining the appropriate referral and trying to avoid possibly harmful effects of unnecessary custodial institutionalization.

Mindlin (62) and others (35,46,49) recommend, à propos the admission procedure problem, that custodial facilities be under continual evaluation for the effectiveness of tentative or experimental programs on kinds of drinkers. They believe that for those who now form the hard core (the majority) of 'incurables' by any known system, there can be developed more efficient programs, by refining screening procedures coordinated with various kinds of treatment.

Treatment - Existing

Six of the programs under review can be termed chiefly educational, consisting of lectures on alcoholism, group meetings and pamphlets on the subject. These are all voluntary within the

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[4] D.F.Mindlin: "The Characteristics of Alcoholics as Related to the Prediction of Therapeutic Outcome," Q.J.S.A. 20: 608-9,1959.

prisons, four of which (2,5,16,61) appear to be primarily for drunkenness offenders. In the other two (10,24) the volunteers are usually men with an alcohol problem who have been convicted under other charges. Two of the programs (5,16) have other rehabilitative activities. The former provides group therapy sessions, the latter allows the prisoner to use the jail as a halfway house for part of his sentence while he works outside during the day. (He is encouraged to return when his sentence is up to help others in the program).

Work programs are a part of the rehabilitative treatment in all but four of the facilities (3,14,25,39). In 6 cases the work routine seems to be the central or major part of the program (4,17,30,43,44,52). The persons who run these institutions justify the use of work programs on the grounds that they are beneficial to the inmates and that they help maintain relatively large custodial institutions with a minimum of cost to the government. Thirteen (3,8,15,16,25,37,39,41,43,51,55,57,34) have a specialized rehabilitative staff and all of them are in a separate establishment from the normal penal institution with the exception of two (16,39).

Thirteen custodial programs have specific follow-up procedures for post-release help. Only one of these (37) indicates that post-release supervision may have some compulsion to it: it is a probational system of out-patient care after intensive in-patient treatment. It is likely that the institution in Herstedvester (Denmark) (25) also has an element of compulsion to it in the light of its other programs, but this is not mentioned specifically. The rest of the rehabilitative programs for post-release support are voluntary. Ten of the 13 mention specific post-release help for which they are responsible. The remaining 4 (24,30,52,59) mention only post-release referral to existing community agencies, primarily A.A. sponsors and groups.

Of the 10 with specific programs, four (19,25,34,37) give material aid such as loans, financial aid or food and clothing; 7 (10,15,16,17,19,34,44) make sure the man has food and shelter. Two have coordinated halfway houses or hostels for post-release shelter (10,17). Six (19,25,37,44,52,59) indicate that a part of their post-release program is getting jobs for their clients or attempting to do so. Three (25,30,34) do substantial social work for released offenders, such as establishing them with a family and an employer; and the Herstedvester asylum (25) appears to concentrate on this type of rehabilitation with continued psychiatric help and social support as well as material aid (employment) and medical (Disulfiram) assistance.

Treatment - Proposed

Almost half of the proposals recommending custodial facilities have no concrete suggestions to make regarding the type of treatment to be given in them. They merely make such suggestions as "should be treated there" or "rehabilitation program" (1,6,20,22,23,26,29,47,50,56,58,62) Two (26,62) specify work programs in a farm or camp but this seems to be the extent of their rehabilitation efforts.

Two others (35,37) give as their reason for not specifying a treatment program in detail the fact that since no known program has been effective in any great degree with this kind of drinker,a suitable program would have to be worked out.

Those proposals that describe suggested programs concentrate mainly on social rehabilitation, both in the custodial institution and following release. Occupational therapy is part of 5 programs - 3 of which would include vocational training (21,33,62). Six indicate that their custodial treatment would be followed by social work, such as helping the person find a job, giving material support after release (21,45,46,50,60,62). Four suggest the use of parole to maintain this post-release

program (45,46,50,60)and one (33) indicates only that 'close supervision' should be used. Three of these (25,46,60) and one other (21) specify the use of a halfway house facility for post-release support.

Two of the proposals give less specific outlines of their post-release program, suggesting in one case merely 'gradual re-integration into urban life' (62) and 'preparation of the environment into which the patient will be released'(

Other aspects of the custodial in-patient programs are psychotherapy, physical rehabilitation, medical treatment [for chronic medical conditions (46,60) and medical treatment during 'drying out' (53)]; education; A.A.; and a program for improvement of work habits. One proposal, aimed primarily at severe cases of chronic alcoholism, would use analeptic shock, conditioned reflex treatment, and if this fails, lobotomy.

A number of programs recognize the lack of a known effective treatment for a majority of this kind of drinker by by recommending long-term or indefinite custodial care for them, or for those with a poor treatment prognosis (1,21,23,33,36,49,62). Three make the qualification that this should be undertaken only in the hope that continuing attempts should be made to find more effective treatment for them (1,35,49).

Assessment of Results

It is difficult to form a generalization of the value of custodial institutions for the treatment of C.D.O.s as they exist since (a) treatment is so varied, (b) only 10 of those mentioned here give any quantitative results, and (c) those use differing criteria of success.

The police department rehabilitation centres of Los Angeles (44) and Seattle (52) have the same standard of success, which is that in each case about 50 per cent of those treated have not appeared again in the court from which they were originally committed. The limitations of this as an index of treatment efficacy are obvious.

Seven have had intensive follow-up surveys of their clientele (8,25,34,37,41,51,59). The Herstedvester asylum (25) used the criterion of subsequent criminal recurrences, since they were dealing with chronic criminals of all sorts, and did a comparison of alcoholic and non-alcoholic patients. They found a lower frequency of criminal recurrence among alcoholics than non-alcoholics (13% to 21%) released on parole over the same period. Santa Rita Rehabilitation Center (51) used two categories based on those individuals with and without social resources. Of those with social resources (that is, with some family ties, better educational background, higher vocational skills, and a more successful employment record), 24 per cent were abstinent, 19 per cent improved, 15 per cent were unimproved, and 42 per cent could not be located or had died 6 years after the Center's inauguration. Of those without social resources (the larger category), 4 per cent were abstinent, 6 per cent showed some improvement, 31 per cent were unchanged, and 59 per cent were not locatable over the same period.

The District of Columbia Workhouse (37) used an evaluation involving drinking behaviour and social adjustment as measured by work, social relationships, and number of arrests. According to these criteria, 32 per cent were considered to have improved, 45 per cent showed no changes, and 23 per cent could not be traced, in a follow-up covering three months to three years.

In Ontario, a follow-up study compared patient adjustment following release from the A.G.Brown Memorial Clinic during the years 1952 and 1961(34).Adjustment was described as 'satisfactory' and 'unsatisfactory' - the variables used including 'abstinence' (not absolute abstinence but admitting of degree and difference) over the one-year period; job performance, evaluation of family

and interpersonal relationships; and the number of drunkenness offences. Using these indices, in 1952 adjustment was considered satisfactory in 43 per cent of the cases. In 1961, 27 per cent were considered to have made satisfactory adjustment. (The drop in satisfactory adjustment was partly accounted for by a trebling of the population in 1962 without a parallel increase in staff.)

The criterion of success used in the Westchester County Penitentiary study (59) is the non-return of the offender to the Penitentiary (which is a short-term institution with sentences up to one year). Over the past 9 years, 38 per cent have not returned; 10 per cent have returned once only; 9 per cent twice; 22 per cent 3 to 6 times, and 21 per cent more than that.

The two remaining institutions for which there is evaluative material (19,14) are both county jail clinics; one (14) states simply that 26 per cent relapsed within the year and the other has the record of 90 (20.9%) working (from 2 weeks to 2½ months) and 125 (29%) who have not returned to jail out of a total treated population of 430.

Only 7 institutions appear to have had a genuine interest in establishing the effectiveness of their treatment through their follow-up surveys; the rest appear to be primarily interested in justifying the continuation of their program by presenting favourable, if inadequate, statistics. None includedthe kind of scientific controls necessary to arrive at valid conclusions or to make reasonable generalizations.

Two Examples of Custodial Institutions

The Saugus Rehabilitation Center in California is an example of a custodial institution offering fairly extensive treatment to its inmates. It is a minimum security institution some 40 miles from Los Angeles for men sentenced by the Courts on drunkenness or related charges, and men committed as inebriates under the Welfare and Institutional Code. It is operated by the Los Angeles County Sheriff's Department, Corrections Division. All the men who volunteer are included in the program except those unable to take part due to feeble-mindedness or inability to understand English.

Since the majority of sentences are for no longer than four months, the turnover is rapid and long-term treatment impossible. Therefore treatment is aimed at getting through to the men, making them aware of their condition and of the necessity for treatment, and motivating them to seek voluntary treatment on their release.

Group therapy with active involvement of the staff appears to be most successful in terms of participation. The men seem to need the support of the group. The leader acts as a teacher and the men become students. A variety of 'teachers'- physicians, social workers, educators - take over the group, discussing a variety of subjects, from the effects of excessive drinking to job opportunities in the area.

Criteria for success must be primarily whether the men entered therapy after release, and secondarily, whether they remained sober or were not re-arrested on drunkenness charges. Since only 30-day follow-ups have been undertaken, the low number of men who resumed drinking or were re-arrested can not be considered a reliable indication of success in that direction. Similarly, where half the men referred to treatment agencies had followed through with treatment, if the resources for treatment in the community had been more adequate, the numbers might have differed considerably.

Bridgewater: The Massachusetts Correctional Institution

Bridgewater houses men sentenced for drunkenness for 2 to 6 months hard labour, and alcoholics who are committed for any period up to 2 years. In 1957, the number of admissions was approximately 4,000 with up to 1,500 at any one time.

The professional staff consists of two social workers, one part-time psychiatrist and one part-time psychologist.

The men, who are sent from the courts, are all repeated offenders who are considered to be serious, chronic cases. Only 3 per cent of all persons arrested for drunkenness in Massachusetts are committed to Bridgewater.

After the usual admission procedure, the inmate is sent to the Prison Hospital, where he spends at least one day 'drying out,' is examined by the doctor and may stay longer if it is considered necessary. He is then given a work assignment either on the farm, in the hospital, in the kitchens or laundry, or in one of the variety of workshops which produce many of the material goods which are needed in the whole Institution, such as the canning factory, weaving and mattress shops, the garage and electrical shops. The individual is usually assigned to work which he performed on the 'outside' or which he learned during previous incarcerations.

Recreation is provided in the form of television, films, shuffleboard, and occasional concerts given by outside groups. A library is also available but the books appear to be few and outdated.

Actual treatment is given to a select few (in 1964, about 50 out of 800 inmates). These are men who are considered best treatment prospects, under 50 years, with some family connections, still employable, and with an expressed desire for treatment.

Treatment consists of group counselling, usually by a social worker, at one weekly hour-and-a-half group session, and a weekly A.A. meeting with compulsory attendance for those in treatment. (Others who are interested may attend the A.A. meetings voluntarily.) There are also occasional films shown on alcoholism. A member of the family of the treated inmate who comes to Bridgewater may be seen for a counselling session by the social worker.

The staff of the Institution can recommend release of the inmate any time between the second and sixth month. Most are released soon after the minimum two-month period, including those in treatment. Upon release, the men have a small sum of money (about $6.00) which they have earned in the Prison. There is no attempt to assist them in obtaining lodgings or employment or referring them to agencies. Those who come from Boston are transported back there by bus, where they are left to their own devices and to the company of their former cronies.

Summary of Basic Ideas and Discussion

The idea behind present use of custodial institutions as treatment centres is that simple jailing has never cured chronic drunks nor cut down recidivism. The law requires that public drunks be fined or jailed. Since these men seldom seek treatment when they are outside of jail, let us utilize the chance to treat drunkenness offenders while we have them.

Those who propose the use of such institutions seldom suggest them as the whole answer or as the best one. They do justify their proposals by citing the need for a protective environment for chronic drunkenness offenders; the probability that development of treatment methods for this kind of drinker can best be done in a controlled setting such as a custodial institution would offer; or the belief in the use of enforced treatment.

The proponents of custodial institutions feel that the chronic drunk is not so much addicted to alcohol as unable to maintain the normal patterns of social behaviour, a situation aggravated by his assimilation into Skid Row, which helps maintain certain behaviour patterns, including his drinking habits. They feel that although some chronic drunkenness offenders are physically dependent on alcohol and require special treatment, most require 'socialization' to the normal relationships of society. Custodial institutions are necessary to control the C.D.O.'s environment and behaviour while he is assisted to gain vocational ability, psychological stability and occupational security. Because of his dependence on Skid Row he normally lacks the motivation to take part in out-patient programs.

It is therefore the social, economic, and psychological rehabilitation which is particularly stressed in the proposals for custodial treatment. Only one program (31) - and it is aimed at chronic alcoholics - specified using alcohol aversion therapies such as disulfiram and conditioned response. Two programs (20,46) which deal with the C.D.O. problem explicitly suggest that alcoholism is a major problem for this population and warrants special treatment.

Otherwise the programs are based on the building up of the social assets of these men.

The actual programs in operation tend to stress work therapy and education regarding the problems of alcoholism. Work therapy, particularly where it is slanted toward job training, could be considered as aiming in the same direction - i.e. toward social rehabilitation. (In the case of Saugus, for example, considerable emphasis is placed on nursery-gardening. This is a useful trade to know in California and could help in post-release rehabilitation.)

It is possible that the emphasis on education about alcoholism and its effects, however, is due to the lack of funds, or energy, or expertise to put it anywhere else. It takes less money and thought to hand out pamphlets, to arrange for the odd lecture or to allow A.A. to hold meetings, than to set up a psychiatric and social work unit with all the complications of such a move. The work therapy aspect has the merit of keeping everyone busy or happy: the prisoners busy - possibly happy - by making a little money, even learning a trade; the prison authorities happy be reducing maintenance costs and showing a busy, productive prison population to the outside world.

A point in favour of custodial programs is that theoretically all chronic drunkenness offenders can be treated, even (presuming the programs are compulsory) the reluctant or recalcitrant who would normally refuse voluntary treatment. In the event, however, screening is frequently used so that those who most need enforced treatment are those least likely to get it. Another favourable aspect is the job training which is less likely to be given in other treatment settings and which can facilitate eventual rehabilitation.

On the whole, the use of custodial institutions, whether actual or proposed, seems to be attended with a certain pessimism or futility. The custodial institutions are, as a rule, proposed for that residue of men, variously termed 'resistant,' 'derelict,' 'deteriorated,' 'incurable,' who in fact make up a considerable

proportion of the C.D.O. population. Some authors feel such Skid Row types should be put into a long-term custodial setting regardless of its therapeutic value, to keep them from hurting themselves or others and to treat them in a humanitarian way. It is pointed out that the cost of long-term treatment could be accomplished with little or no extra expense to the community since C.D.O.s are at present a major expense to the law enforcement and penal establishments. The rider is usually added, that there should always be "opportunity for rehabilitation," which may be an unintended euphemism for shelving the problem.

Corwin and Cunningham (12) conclude their summary of facilities for the treatment of alcoholics with this fairly typical, negative, attitude regarding the case of the chronic drunkenness offender (although they do not name him as such).

> It has long been recognized that there is a group of alcoholics who do not wish to abstain and for whom provision in medical institutions is a social waste ... Such alcoholics are rated hopeless by all standards of management ... Work colonies for the physically fit among them and custodial institutions for the others, are probably the most rational solution. Yet a certain amount of hesitation is felt in recommending the establishment of such institutions, since it is realized that, unless someone is constantly alert, they may become a catch-all for all types of alcoholics ... Patients should be committed to such institutions only as a last resort, when every means of securing their active cooperation has been exhausted. (p.83)

The proponents of custodial institutions are less enthusiastic than their opponents are vociferous. Judge Lohman (32) says categorically, "I have yet to find any jail or penitentiary which rehabilitates anyone." (p.34).

He also says:

> Over half or more of the men in the jails and penitentiaries of the United States should never have been sent there in the first instance. I say this because in over half of the cases there is nothing in a jail or penitentiary that could possibly by any stretch of the imagination come to grips with the condition or circumstances which brought about the attention of the law in the first instance. (p. 33)

To be sure, he is speaking generally of incarceration and not of treatment in custodial institutions. Nevertheless, his further points are relevant; that jailing, even where treatment is offered, estranges the individual from society, demeans the individual in his own eyes, and creates a stigma on the part of the family, employer, society in general. This degradation might be overcome by intensive therapy, but the usual short-term incarcerations for drunkenness are not (necessarily) sufficient for adequate therapy. As a means of preparing the men for treatment, it seems useful, but obviously the program needs to be extended to cover post-release treatment, clinics, halfway houses and so on.

If chronic drunks are going to be treated in custodial institutions, then the attitude of the public and the nature of the law will have to change to make ultimate sense of such a program.

COURT SUPERVISED SYSTEMS

These are defined for our purposes as those non-custodial programs that use the power of the court to influence chronic drunkenness offenders to seek to rehabilitate themselves. Treatment or help is made available and usually proffered as an alternative to a fine or jail sentence. Parole, probation and suspended sentences are utilized to allow the offender to take treatment, and possibly as a threat to see that he does.

The type of program varies: it may involve attending a class once a week, or an out-patient clinic, or a rehabilitative program of some kind, as a requirement of probation. Such court-supervised programs are distinct from custodial (jail) programs in that the individual is free to carry on his normal life outside the requirements of the program. Within the program, however, he is under the supervision of the court and subject to possible punishment by law.

Court supervised and custodial programs are the ones most likely to handle chiefly chronic drunkenness offenders because of the conjunction of drinking with a legal offence that brings them within the jurisdiction of the court. Hence court programs have certain possible advantages in the treatment area: (a) they offer a means of reaching the C.D.O.s and getting them into treatment; (b) under probation supervision with the threat of a fine or jail sentence if the terms are not met, they may provide a more effective way of keeping the C.D.O.s in treatment than if they were purely voluntary.

Twenty-four court programs were found and some eleven proposals for such programs.

Auspices - Existing

The court has usually been the moving force behind existing programs. Some have been started specifically by the presiding judge (9,10,18,30,35); others probably by the combined efforts of judges, probation officers and social workers - and

one (28) by the Municipal Court Psychiatric Clinic. Funds, where funds are necessary, appear to come from the municipality. In one program in Massachusetts (9) the clinic staff, consisting of a psychiatrist, a physician, and a psychologist, are all unpaid volunteers.

Frequently existing services in the community, from A.A. groups to Alcoholism Clinics, are used - the judge stipulating attendance at whichever facility he finds available.

In 11 of the programs the treatment facilities are supplied by a special auxiliary service of the court (3,5,6,7,9, 20,21,27,30,36,39). In 5 cases this is a clinic (7,9,20,21,27). In 3 it is a probation officer or officers attached to the court, and in Royal Oak, Michigan (10) it is a group of volunteer probation officers, private citizens from the community. In yet another (6) it is an advisory committee of members representing various private and public agencies.

In 4 cases (10,18,30,35) the facilities used are simply the courtroom where meetings are held weekly and material assistance is given from the court's resources or from charitable agencies. In Portland, Oregon (6) the advisory committee refers the person to one of the numerous agencies which the committee represents, and the probation officer in Prince George, Md. (5) does the same thing. In the remaining programs the facilities are operated by nearby treatment centres in cooperation with the court. These are such publicly supported institutions as Alcoholism Clinics or University Clinics.

Auspices - Proposed

There is no suggestion in any of the proposals that anything but the court handling drunkenness and related offences would be the prime motivating power behind this kind of system.

Frequently the judge or magistrate would act on the advice of an attached clinic or 'screening staff' (8,11,16,19,26,28,32,33). Six of the proposals define this auxiliary to the court by function or membership. One (28) suggests a single probation officer trained in alcohol problems, another (11) suggests 'penal and treatment officials', and yet another (32) an 'adequately trained staff' to evaluate the offenders' medical, psychological, and social capacities and needs. One proposal (26) suggests the use of an objective screening scale.[5]

Other proposals are less specific regarding the actual type of professional assistance to be given, suggesting in one case (8) that the Court should have the advice of an evaluating expert, and in another (16) that screening for appropriate referral should be given those who volunteer for clinical treatment. Two others (15,32) make the same point in even more general terms, one (32) being the criticism of a Toronto magistrate who says there is no time or clear-cut ability to screen applicants for the A. G. Brown Memorial Clinic at the present time.

At this juncture the offender is in the hands of the court. Under whose control would he be after sentencing? Few of the proposals make any definite suggestion for this. One which is a probational system (28) suggests that a combination social worker-probation officer be employed to supervise the individual, and another (1) recommends individual case-management or supervision.

Facilities to be at the disposal of the court include court clinics (1,16,26) and a compulsory C.D.O. camp (26). Others which propose a court referral system do not specify what facilities would be used (11,32), although one (28) mentions the need for 'coordinated facilities'.

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[5] This is the Mindlin Scale for evaluating and predicting the potential of alcoholics for successful treatment therapy.

Whether the court-referred patients would be under the ultimate management of treatment or of penal officials after leaving the court, is a very significant area for consideration which is not touched on in any of the proposals.

Duration - Existing

Court supervised systems are relatively new, the earliest encountered in our search being the Cleveland Court Clinic (27) which started in 1940. A municipal court class program started in Des Moines, Ohio in 1956, and similar programs were begun in Denver, Colorado and Washington, D.C. in 1958. The Atlanta Court Clinic was started in 1963 as part of the Emory University Project. At least half appear to have begun in the '50s.

On the whole, the court systems appear to have sprung up as the result of certain individuals attempting to deal with an immediate problem in a specific situation, within the existing facilities and laws, rather than following on widespread theories and studied recommendations.

Dates and Backgrounds of Proposals

The recommendations tend to have followed after the fact: three of the proposals were published in the 1960's (16,26,32), 5 in the late 1950's (11,13,19,28,33) and 3 were published in the late 1940's (8,15,32). Four of the proposals are the result of the work of committees or commissions. Two were governmental bodies (26,32), municipal and state respectively, and the other two were county (11) and regional (28) committees on alcoholism.

One is the result of a research project carried out by the Emory University, Department of Psychiatry, in the city of Atlanta (16).

The other 6 are contained in papers by individuals whose primary concern is the need for reformed court practices in

dealing with alcoholism or drunkenness offenders. These include a newspaper's quotation of a magistrate (32).

The committee and research projects are lengthy studies which tend to propose multi-faceted programs of which a court voluntary system is only one part (11,16,26,28,32). The rest focus on the need for the court to be allowed to use its influence to promote some kind of treatment program. Several of the multi-aspect programs propose different dispositions for kinds of drunkenness offenders (on a variety of distinctions) and suggest a number of appropriate facilities; and one of the shorter articles (19) also proposes a variety of treatments for different kinds of C.D.O.s.

One 1968 paper (23) does not make a specific proposal but it does make a relevant observation. It is a study of the efficacy of 3 types or 'degrees' of punishment on reducing recidivism of Skid Row chronic drunkenness offenders.

Admission Procedure - Existing

Initial eligibility requires arrest for public drunkenness or a related offence. Then the law prescribes, or allows the Court to prescribe, some form of treatment other than simple incarceration or punishment.

In two jurisdictions (4,22) the consent of the accused is not necessary for him to be placed in the program. In 5 jurisdictions (2,5,10,18,35) the accused is offered the chance to enter the program and is automatically accepted if he volunteers. The remaining programs also require the participant to volunteer, but there is a further screening process by the Court or advisors to the Court (such as a police officer (3), social worker (31), probation officer (30,35) or court clinic (28). The participants may be selected from among the volunteers on the basis of their past record of arrests (9,24,27,35), on the assessment of their motivation for rehabilitation (30), in one case (7) for their

ability to take Antabuse, and in one experimental project (34) on the basis of random sampling or else on the basis of certain characteristics of their personal history which are considered necessary for potential success(such as a certain amount of family and job stability)(39).

Admission Procedure - Proposed

Among the proposals for setting up court supervised systems are 6 which suggest an amended code allowing special treatment for repeating drunkenness offenders (8,15,16,26,28,33). Two proposals (16,26) specify what the code should be. One (16) would allow the possibility of voluntary committal to a specialized custodial establishment; the other would allow the alternative of probation on condition of accepting in-patient or out-patient treatment at a clinic, as recommended by the court - for one year or two years in a C.D.O. camp. The use of the clinic care would be decided by applying the Mindlin scale. This latter proposal is the only one specifying a definition of a chronic drunkenness offender.[6]

Whereas the basic requirement for admission to court programs would still be coming in contact with a court for having committed some kind of offence, one proposal (32) would recruit from other than the drunk courts; for example, from family courts where alcoholism and drinking problems are frequently involved.

Some programs (11,19,32,33) which advocate advisory auxiliaries to the court do not indicate the basis of selection of offenders, other than by "psychiatric screening"(19), "treatment and penal officials," "medical and social service personnel"(32) or separation of the alcoholic from the non-alcoholic drinker (28,33).

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[6] In the context of Maryland law, it is a person convicted of drunkenness 8 times in the previous 18 months.

Neither the simple expressed desire of the offender to be rehabilitated, nor the very condition of being a repeated offender, is deemed sufficient in these program proposals for the offender to be sent to treatment. Professional advice is considered necessary to assure the court of the appropriateness of its referral and judgment. This is directly stated, as noted above, by a Toronto magistrate with reference to the A. G. Brown Clinic (32).

Treatment - Existing

The type of treatment offered in the court programs varies from mere probation with advice as to which agencies might be available to the offender, to all-round treatment including psychotherapy.

One type of treatment may be described as court-supervised abstinence programs. They are put into effect through the use of either suspended sentences (7, 15) or, most frequently, probation. Five of these are Court Honor Classes (5,10,18,30,35). These involve an informal weekly meeting, on a Saturday morning or an evening, conducted either by the presiding judge (10,17,35) or the probation officer (5,35). Run somewhat along the lines of Alcoholics Anonymous, the meetings are used to inform the chronic drunkenness offenders of the dangers of uncontrolled drinking and to discuss the practical problems for these men in achieving sobriety, and pointing out various community resources. These meetings differ from A.A. in that attendance is compulsory. Usually, however, there is at least one representative from A.A. present. In Des Moines (18) a doctor is in attendance to give the men free Vitamin B-1 shots. In all the Court Classes material help is given in the form of clothes, assistance in getting jobs, and arrangements with other agencies for temporary food and clothing. These services seem to indicate some social work facility which is not specifically mentioned.

The 6 programs (2,7,9,15,24,28) that use other public facilities attempt to get specialized care for the chronic drunkenness offenders. These facilities have professional specialists and/or a specialized function in treating alcoholics. They are alcoholism clinics, only one of which (2) offers a period (8 weeks) of in-patient care, although all have the medical, psychiatric, and other facilities for specialized care of alcoholics. One program was an experimental situation in which the chronic drunkenness offender (two drunkenness arrests in the previous three months or three in the previous year) was given a 30-day suspended sentence on condition of one year's total abstinence (15). The 301 sample subjects were sent randomly to one of the 'treatments': no treatment, A.A., or an alcoholism clinic. Disulfiram is the basic part of one (7) program which screens volunteers to make sure they can take it. It is administered daily under the supervision of the probation officer for the period of the suspended sentence: 30 or 60 days.

Other programs (7,9,12,20,22,40) use Disulfiram as an adjunct to their program. Several of those which are chiefly referral programs direct the probationer to Alcoholics Anonymous (2,4,7,15,27,31,36). A specific attempt at social rehabilitation is made by the use of a halfway house (17) or hostel for some of the group in one program; another (9) indicates it will obtain jobs for its clientele if they need them. Three other programs (21,27,28) offer out-patient treatment, medication, group therapy, employment and social rehabilitation. One program (36) is based on group counselling, with group discussions, films, A.A. speakers, and representatives of community agencies, as well as counselling. One other program (38) involves commitment for 60 days, under local legislation, to the alcoholism clinic in a county hospital, where full medical treatment is given.

The Danish system (20), in which probation is on condition of 4 years' treatment, deals with its subjects on an out-patient basis but uses intensive social casework and psychotherapy; also drugs, together with considerable material aid and economic support.

It stresses the fact that group therapy is not used. The compulsory Finnish system (22) uses both in-patient and out-patient treatment with intensive social work and Disulfiram.

One program (3) simply places the drunkenness offender on probation with no specific treatment program, and this is done as part of an experiment in another (15). In the former, the probation officer will direct the offender to existing agencies if he wants to use them, and support him in his abstinence attempt.

Treatment Programs - Proposed

Only four of the proposals suggest specific treatment programs to be put at the disposal of the court. Aspects of these programs include: employment (13), social work (13,26), probational Antabuse program (17), clinic treatment (17,26), and counselling (26). The remaining proposal arises from the observation that of 3 types of court punishment, i.e. jail sentence, suspended sentence, or fine, the fine appeared to have the greatest deterrent effect on recidivism. Whereas a second arrest for drunkenness occurred on the average 60 days after release from jail and 62 days after suspended sentence was given, a mean of 73 days transpired after the arrest of those Skid Row offenders who had been given a fine (23). (This result might be more meaningful had there been a random assignment of the 3 types of punishment, thus eliminating any bias on the part of the judge.)

Apart from these four papers, the proposals use such general terms as 'appropriate treatment,' 'multi-discipline approach' to indicate that the program is intended to rehabilitate rather than penalize the offender.

In general, the proposals for court voluntary systems tend to concentrate on functions of the court in relation to the alcoholic; that is, how the alcoholic or C.D.O. should be dealt with in and by the court, rather than on specific treatment programs for him.

An Example of a Court Supervised Program

In Cincinnati the Municipal Court conducts a cooperative program with the Alcoholism Clinic attached to the Cincinnati General Hospital. The drunkenness offenders are evaluated as to their rehabilitative potential by a team consisting of a psychiatrist, a psychologist, and a psychiatric case-worker who is also the probation officer, from the court's psychiatric clinic. On the basis of the team's recommendations the judge may place the offender on probation with the stipulation that he attend the Alcoholism Clinic regularly. The mere threat of punishment for violation helps propel some drinkers into treatment. Others need constant supervision by the probation officers to get and keep them there.

There is considerable liaison between the Court and the clinic since the same psychiatrist is employed by both and the probation officer follows the patient's progress through from the court to the clinic doing casework therapy where necessary (or possible) with the wife.

The criterion of success of this court program appears to be how many of the court-referred men reach actual treatment. In 5 years the proportion increased from 21 to 88 per cent.

We do not know the percentage of C.D.O.s who are considered suitable referrals by the court clinic team, nor the amount of sobriety achieved by those who undergo treatment. The program appears to be suited to the more motivated, more recent entrants to the C.D.O. way of life.

Assessment of Existing Programs.- Fourteen of these facilities give some quantitative calculation of their results (2,6,7,9,15,17,20,21,22,24,28,34,35,39). Each program must be assessed on its own merits, since the results overall cannot be compared, as the criteria for success vary. Abstinence, lowered community rates of arrest, individual arrest records and improved social ratings are the main criteria of success. But even where

abstinence is the criterion, the varying lengths of abstinence periods selected make comparisons invalid.

Very remarkable results were obtained in 1942 by the Cleveland Municipal Court Clinic (27), where an independent observer found that 81.4 per cent of the better than 90 per cent follow-up were abstinent (269 for more than 9 months; N=397 out of 487; 219 for less than 9 months follow-up) and only 20 per cent relapsed. During the study only 5 per cent refused to volunteer for clinic treatment, which included medical treatment, recreation, and occupational programs. There was also a very great improvement in their arrest record as compared to a control group.

One study (35) considered a success to be lack of re-arrest within 6 months, in which case over 50 per cent were successful.[7]

The Virginia Clinic (21) also yielded exceptionally good results. A 3-year follow-up indicated that out of 1,049 treated, 57.2 per cent were helped to gain sobriety; 22.5 per cent had improved family relationships; 20.3 per cent showed no improvement.

In Portland, Oregon (6), of 8,000 convicted men, all of whom were given a 60-day suspended sentence and told they could get help from an advisory committee, 1,274 asked for this help. Of those who received this help, 979 had not been re-arrested one year later.

The Court Honor Class at Des Moines, Iowa (18), claims a decrease of 35 per cent in the number of drunkenness arrests over a 7-year period.

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[7] The relevance and validity of using law enforcement statistics as a measure of anything more than just that (including the efficacy of an alcoholism treatment program) is somewhat suspect, of course.

The San Diego program (14,15) experimented with three types of 'treatment'. Of 301 cases, data on 241 were obtained for one year after arrest. Eighty-five, or approximately 35 per cent, had no re-arrests in this time. However, forced referrals to Alcoholics Anonymous and to the alcoholism clinic were no more effective in preventing re-arrests than simple probation with suspended sentence and no other treatment.

Of 3,000 court volunteers to the alcoholism clinic in Chicago, where a full range of treatment is given, one half have stayed sober - but we do not know over how long a period.

In the program (7) where the treatment consisted of a daily dose of disulfiram, at the end of 3½ months 61 of 132 persons were still actively taking the drug. Since many of these had been jailed frequently over a long period for drunkenness offences, this was thought to be very encouraging.

In Denmark (20), of 44 patients treated for 12 to 20 months, 37 had no conflicts with the law during this time. In Finland (22), where treatment was compulsory, 191 of 533 patients treated during 1947-51 had either totally abstained or were sufficiently controlled to have made a good social rehabilitation; 342 persons, however, had 'negative' results.

One program (34) sent men randomly to two different facilities as an alternative to detention. Although one was in a pleasant setting with emphasis on psychosocial rehabilitation and the other was in a barracks-like atmosphere with no rehabilitation services, 60 per cent of all men sent to both completed the voluntary 60-day term of treatment. In one other program where the treatment consisted of a casework service, only 5 of 85 failed to appear for their appointments and 60 per cent had no further contact with the law during the survey period (6 months to 3 years). However, the careful selection of defendants for social stability characteristics makes it unlikely that any Skid Row C.D.O.s entered the program.

These programs deal more specifically with repeated offenders than other programs, with the exception of custodial. Generally the results seem to be in contradiction to the view that chronic drunkenness offenders cannot be treated successfully on an out-patient basis.

Summary of Basic Ideas Behind Proposals for Court Systems

The proposals for court supervised systems are based on several premises. One is that drunkenness is not, or should not be, considered a crime in itself and therefore that these men, the chronic drunkenness offenders, do not belong in jail. Another is, that the normal penal disposition of the court is costly and ineffective, since it fails to deter the chronic drunk from repeating his offence. Yet another is that the existing method of processing the C.D.O. through the court and into jail lags behind contemporary humanistic values.

The various proposals reveal the broad consensus that the time to catch the C.D.O. for treatment in his typical life cycle is when he is being sentenced by the court; or if not the time, certainly an auspicious time, since he is readily available. The court defines him by its action; it is part of his regular cycle and has the power (given the appropriate laws) to direct him towards rehabilitation.

The authors of the alcoholism study project of the Emory University Department of Psychiatry say they would not suggest changing the law that public intoxication is a misdemeanor but would allow it to remain "as the means whereby these individuals are brought to the attention of the facilities which are best equipped to handle the individual's problem." (17, p.49)

Other authors feel that alcoholics, so often lacking in self-discipline and self-control, need the authority of the court, and its powers of coercion, either to propel them into treatment of some kind or to compel them to maintain sobriety

for longer than they might do if they were not on probation.

Probational control is not generally accepted by all investigators as suitable for all C.D.O.s. Since 'hard core' C.D.O.s do not change their ways after punishment (i.e.jailing), it is felt they will not be controllable by the threat of punishment. Probational control would thus involve selective referral, selection being based on certain characteristics which hold good prognosis. In some programs (19) probational control would then be only a part of a larger program where C.D.O.s would be sent to treatment appropriate to their needs and prognoses. The study suggests that probation is less effective than a fine in reducing recidivism, presumably because it takes money that might otherwise be spent on liquor.

It is recognized in these recommendations that there is no simple solution to the problem of the C.D.O. and no single kind of program is agreed upon. However, it is generally agreed that social rehabilitation is most important.

All proposals suggest some kind of advisory personnel, individual or committee, with specialized knowledge to help the court determine the most appropriate treatment for each case.

Some feel that it is compatible with social work and would combine the two in one court officer to give him the dual role of controlling and supporting the behaviour of the offender.

There is a general agreement running through all the proposals that a variety of alternatives should be open for the disposition of this kind of offender according to his potential. Changes in the law for the C.D.O. must be coupled with the making available of appropriate treatment and care.

The same theoretical bases no doubt underlie those court programs already in existence. However, most of the programs tend to be the result of sheer desperation on the part of those persons (usually the presiding judges) who have been faced with

the daily roster of chronic drunks. Seeing the same faces over and over again, they became all too aware of the futility of jail sentences in reducing either the number of drunkenness arrests or the amount of recidivism. Within the bounds of the powers of the court, they attempted to do something else with these men, using what facilities were available in the community, mobilizing agencies and individuals to action where professional staff were unavailable. One judge, in Royal Oak, Michigan, for example, called for volunteers among the leading citizens to act as probation officers. He has been so successful that each volunteer is responsible for at most two offenders.

From arrest through to jailing, the situation which seems most de-humanized is the drunkenness court where offenders are ground through the mill almost by rote and as fast as possible, (one every 50 seconds in Toronto), (The Chronic Drunkenness Offender, Chapter V, The Courts,p.8-9). It is there, according to their own reports, where they feel humiliated, 'herded in there like a bunch of sheep' unable to speak for themselves. Perhaps it is not surprising that whereas the less personally involved proposals tend to suggest selective referral and treatment, those persons most directly concerned with processing them through the courts have undertaken treatment programs that have included all chronic drunkenness offenders.

SKID ROW INSTITUTIONS

These treatment centres are ones that are deliberately located in the Skid Row area to cater to and provide easy access for the chronic drunkenness offender and the Skid Row population. Many of them are offshoots or simply extensions of an earlier form of charitable service based on compassion and missionary zeal; a small number, set up by the municipality, are based less on compassion than on orderliness and a sense of duty to the municipality's citizens. Over the years the problem of heavy and chronic drinking came to be recognized as one requiring a separate or specialized treatment. Although many are still hostels providing chiefly shelter and sustenance on condition of sobriety, others have become rehabilitation centres offering counselling, occupational training and medical services.

A few completely new, experimental centres have been opened which provide detoxication areas, psychiatric assessment, referral to suitable agencies, medical treatment, day care, lodging.

Because these Skid Row institutions are voluntary, a frequent problem is recruitment and those in charge must decide whether to wait passively for clients (in which case they expect to get the better motivated and therefore potentially more successful candidates) or whether to reach out into hostels, courts or the streets taking in difficult or 'hopeless' problem drinkers, in which case their rate of success may be so low that such centres will have difficulty in justifying their operation.

In this survey we have attempted to include only those Skid Row facilities which specialize in dealing with problem drinkers and those that have programs specifically designed to rehabilitate them rather than simply providing them with creature comforts. We found 36 of these.

Among the proposals in the literature for treatment for C.D.O.s we found 12 suggesting some kind of Skid Row establishment.

Auspices - Existing

Most of the existing Skid Row treatment institutions are charitably supported. Thirteen are under the auspices of the Salvation Army. Four are run by the Volunteers of America (9,31,32,33). Seven are operated by a variety of religious institutions or private foundations apparently on a strictly local basis except perhaps for Goodwill Industries (41), which is a nation-wide organization providing sheltered workshops for the homeless, indigent, and needy.

Four are run by Alcoholics Anonymous (12,16,18,19). All four of these are located on Houston's Skid Row. This appears to be far from a representative sample but are the only ones mentioned in the literature surveyed.

Six are programs established by city governments. They are located in Detroit (51), New York, Minneapolis and Amsterdam (10,11,43,46,48). Two (10,48) are part of the coordinated system of the City of New York for rehabilitating Skid Row types or providing them with institutional care (Hart Island, now defunct, and a halfway house - Bridge House). The New York Alcoholism Vocational Rehabilitation Project (11) is also in New York City, but is not, to our knowledge, specifically connected with the city's permanent program and is only tentatively listed as a Skid Row institution because of its vocational counselling function and despite the fact that it seems to be a test project.

In England (52) there are some 10 'hostels' (therapeutic residential community facilities) for alcoholics, including drunkenness offenders, which are supported by Home Office grants. There are also several shelters and 'crypts' run and supported by the Church of England. An outstanding example of one hostel, Rathcoole House (52 - Appendix N) was financed for its first two years by the Carnegie Trust, after which it received a Home Office grant.

One other, the South End Center for Alcoholics in Boston (20) is sponsored by the Massachusetts Division of Alcoholism, together with the Boston University Medical School, Department of Psychiatry, with the aid of a Federal grant.

Auspices - Proposed

Only one of the proposals (45) specifies the administrative auspices of their recommended facility - the Welfare Department (of New York City). Several of them imply that the municipal government should undertake the task, a reasonable recommendation since such facilities would only be instituted in cities with definite drinking problems associated with the existence of a Skid Row area. Other possible auspices mentioned are the general hospital (30) at least for location, and an existing Skid Row institution with a specialized program (33) like the Volunteers of America Men's Service Club of Los Angeles.

Duration of Existing Programs

Of the 20 programs for which we have dates of inception, one goes back to 1898 (21) and one to 1909 (20). The former is a mission and the latter is run by the Christian Industrial League and both have probably changed their program over time. Three other early inceptions are the Swedish Salvation Army farm and colony, one of which dates from 1912 and the other from before 1939 (50), and the Amsterdam First Aid program, which began in 1929 (46). Two originated in the 1940's, 8 in the 1950's, and 5 in the sixties, of which three are in Canada and run by the Salvation Army.

Dates and Backgrounds of Proposals

Of the proposals, two were made in the late 1940's, three in the early 1950's, and five in the 1960's.

Four of the proposals stem directly from research projects on the treatment of Skid Row drinkers and chronic drunkenness

offenders (24,25,33,51). Four others are the views of researchers concerned with Skid Row society and treatment of Skid Row drunks (29,36,44,47) and two (23,45) are the reports of state and city governmental committees to their administrations. The remaining two (30,35) are parts of reports of committees of regional medical associations in the United States on alcoholism problems generally.

Admission Procedures - Existing

Skid Row institutions are truly voluntary since no sanctions such as the alternative of a jail sentence are used to induce participation. Nor are there any punitive sanctions to impose regulations once a person is in the program.

Though voluntary, many do not accept all volunteers. Various methods are used to screen for desirable clientele. For instance, the Salvation Army feels that a belief in God is necessary to a man's rehabilitation and therefore an affirmation of such a belief is explicitly required as a condition of acceptance to the Salvation Army's program. One of the Salvation Army facilities (39) used the Manson Evaluation and Cornell Medical Index tests as a supplementary screening to the religious requirement. The Volunteers of America have attempted to formulate a screening program based on their research project (33), from which they conclude that self-selection through 6 introductory treatments is sufficient to screen out those who do not have the determination to benefit from their program.

In Amsterdam (46), as part of the city's first aid program, a field psychiatrist must investigate any disturbance wherever it occurs and immediately it is reported. One program (41) insists that the applicant be sober when he applies; another, because of its nature (1) would presumably accept only the acutely intoxicated.

One (43) selects its applicants from the relief rolls. Several which are missions (8,40,42) are not primarily oriented to rehabilitation and therefore are not so keenly interested in the maximization of results from the use of their facilities. The others either have not screening processes or fail to mention them.

Admission Procedure - Proposed

Two proposals which delineate their admission process also illustrate two contrasting approaches to the problem of voluntary treatment of Skid Row drinkers. One, the proposal mentioned above, which stems from a study of facilities in Los Angeles run by the Volunteers of America (33) suggests screening out those volunteers with a relative lack of motivation by having them go through a series of introductory interviews and sessions. The study shows that 60 per cent of those who survive the 6 sessions or more, successfully complete the treatment program. This score rises to 80 per cent if they have completed an application form as well. Success in this program is measured along socio-economic variables: increased employment, improvement in the client's means of financial support; improvement in shelter; moving into a residence and/or living in a better socio-economic area than before. The selectivity of approach is indicated in the finding that only 15 per cent of the total number who registered (953) reached a minimal degree of improvement. This kind of admission process makes for high effectiveness by screening out the vast majority of Skid Row problem drinkers.

The Men's Shelter Program of the New York system screens only to determine the needs of the volunteers and to see how and if they can be helped. The screenings, conducted by a professional staff at the Men's Shelter where many are given overnight lodgings, would be to direct various needy types to suitable specialized facilities. The plan as proposed would have a

coordinated screening facility in magistrate's courts for homeless, indigent men appearing there. The aim of this program is general relief to the Skid Row population on a mass scale in contrast to intensive rehabilitation on a very selective basis.

The two approaches are not necessarily incompatible but the New York plan has in performance apparently fallen short of incorporating any particularly intensive rehabilitation facility for a selected Skid Row drinking population.

Failure in the program, or subsequent relapse should not be punishable by exclusion from the program another time (36,45) according to two proposals. It is even considered that the occasion of relapse can be of significant therapeutic value (36). One program would recruit any interested,homeless alcoholic, after an interview with the director (47).

Treatment - Existing

Eight of these voluntarily entered Skid Row institutions barely meet our definition in that they offer little more than board and lodging to the client while he remains sober. In addition, the possibility of conversion to their philosophy is offered in 4 Alcoholics Anonymous houses, and religious counselling probably in the missions.

The others offer various types of treatment and varying degrees of help. One house (19) provides only the additional opportunity for recreation and informal counselling. Others (9,39,41) offer definite work programs which enable the residents to earn a small wage as the core of their rehabilitation or maintenance programs. In one of these (9) a dollar a day is deducted for board. The Salvation Army Men's Social Service Centers (2,4,9,14,44), of which there are undoubtedly many more, including the Toronto Men's Social Service Centre, and assuming they have roughly the same programs, offer no employment to their residents who are, however, required to do housekeeping jobs to

maintain the establishment. These Centres provide medical services and recreational facilities to their residents. The Alcoholic Rehabilitation Project of the San Franscisco S.A. Men's Social Service Center (39), however, provides a much more thorough rehabilitation program. The treatment consists of full-time residence with all the implications of group support, full-time work, religious services, group and individual psychotherapy, medical examinations, psychological tests and vocational guidance - as well as job assistance.

The Salvation Army Harbour Lights, of which 4 are listed (5,6,14,28), although there are many others in North America, are specialized institutions with facilities for programs of long-term rehabilitation for alcoholics, including occupational therapy. These programs are probably based on the San Francisco facility (39) which carried out a 5-year research and demonstration project from 1961 to 1966. The Edmonton Day Centre (4) is also apparently modelled on this facility. It is an open house which shelters homeless, indigent men during the day, offering residential treatment to those who apply for it. All Harbour Lights, however, do not offer this day-care maintenance.

The London Rescue Mission (8) appears to operate on the same lines as a Harbour Light, but on a smaller scale, without day-care or occupational therapy but with the additional services of some employment guidance and family aid.

The Pioneer House in Minneapolis (43) gives some sort of residential rehabilitation but obtains its clientele from the municipal relief rolls and emphasizes the A.A. philosophy rather than any specific religious doctrine.

These residential treatment programs on Skid Row appear to reach a zenith of facilities in the experimental Volunteers of America Alcoholic Treatment Service in Los Angeles (32), where they have a medical clinic, group and individual counselling, and an employment service for those who complete their programs.

Antabuse is also routinely used. Another similar facility is the Adult Guidance Center in San Francisco (37), although this may not be for Skid Row types.

In two cities, Detroit (51) and New York (10,11), there are municipal programs of a voluntary, Skid Row nature. Each offers at least shelter and sustenance on an open house basis, and a referral service. If the individual, while in the centre, volunteers for further assistance, he is screened for the appropriate facility. In Detroit he is referred to social service agencies. In New York the city maintains a number of facilities which are coordinated with the referral centres as outlined above. These centres themselves offer minimal services but they are at the nexus of community programs for those Skid Row men who choose to use them.

In Amsterdam (46), alcoholics - and this would include Skid Row types - are given immediate psychiatric help when assistance is required (it does not have to be asked for by the person involved) followed by intensive "social-psychiatric work" with the individuals involved. Aversion therapy, using apomorphine, is sometimes employed.

In London, England, Rathcoole House (52) provides long-term residential treatment for drunkenness offenders. Since it is an experiment in providing a "suitable alternative" to incarceration, treatment has changed since its inception in 1966. Originally group counselling was provided once a week by a psychiatrist, with generally simple supportive measures. Eventually, the psychiatrist withdrew from the meetings and an A.A. group was formed. The emphasis is now on a therapeutic community with the men taking responsibility, forming policies and selecting residents. Medical services are provided by the local general practitioner.

There is a further facility, or a treatment aspect of a facility, that gathers its clientele from Skid Row populations and transports them out of the city for rehabilitation (7,39,48,50). These are colony or farm type institutions for volunteers from city populations.[8] These are run by the Salvation Army and provide complete institutional care and a work program inside the establishment. They have positive rehabilitative programs as well, but a major emphasis appears to be on getting the individual into a position where he can be occupied in other affairs than those usually involving him in drinking. The S.A. Retreat in Sweden, however, is specifically oriented towards an 'open' unrestricted atmosphere, allowing individuals to leave and even to drink in nearby towns if they feel the need. The purpose is to use the incidence of relapse to convince the patient that he has reached 'rock bottom' and total dependence on alcohol, and thereby motivate him towards rehabilitation, a sequence which has been found therapeutically beneficial. The one in New Zealand (7) operates a halfway house in Wellington for persons leaving the restricted environment of its island setting. Another institution of this kind is Camp La Guardia (48), part of the New York City program. It offers both custodial care for older 'incurable' indigent men and an occupational rehabilitation program for younger more hopeful cases, with job placement facilities for those who complete the program.

The South End Center located in Boston's Skid Row (20) is neither a residential facility nor a rehabilitation centre. Realizing that there are many separate institutions in Boston with their own unique functions for caring for the C.D.O. and other homeless types, the staff decided that the Center's unique function was to evaluate the various facilities in order to refer the men to the appropriate agencies, to motivate the men to use the facilities, and finally (most important of all), to deliver them to those agencies. The linkage role is the

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[8] Two other rural programs are the S.A.'s Hope Acres in Ontario and the A.R.F.'s Bon Accord. (See Appendix I for detailed description.)

novel function here, connecting the men up with the agencies, acting as their spokesman, following up each referral, perhaps later taking them to some other advisable resource, to a job, or to a housing arrangement. This plan is not selective; its aim is "to control the problem of the chronic drunkenness offender on a large scale" (20, p.5).

Treatment Programs - Proposed

In general, the proposals tend to regard Skid Row institutions not as rehabilitation centres themselves but as screening and referral centres. Some of them would, however, offer medical services (26,30), detoxication services (29,33,52), shelter (23,35,51), vocational rehabilitation (35), and group therapy (51). Intensive rehabilitation services are seldom recommended for these facilities. Their role is rather envisioned as coordinating auxiliary agencies such as clinics, halfway houses, custodial institutions, or "existing agencies," and "specialized facilities" - the general terms frequently used. None of the proposals suggests as strongly the importance of the transitional role as described by Blacker in the South End Center.

The Neighbourhood Treatment Units suggested by the Emory University Project to be set up in the most refractory Negro slum areas take into account the need for some groundwork to be done before the person is referred. The staff of these units would establish rapport with the alcoholics and attempt to do some educational work with them before referring them to a treatment centre. They would also do follow-up work with the treated referrals.

Two proposals suggest the setting up of Clinics on Skid Row. One (24), which is concerned with the use of drugs for alcoholics, suggests that a psychopharmacologically-oriented clinic be set up in the Skid Row area specifically for the Skid Row alcoholic. Ditman feels the first step towards rehabilit-

ation is to help the alcoholic allay the symptoms of alcoholism withdrawal, starting him on the road to sobriety. Once this step is taken successfully, the individual could then be given counselling, vocational guidance, and psychotherapy in clinics or physicians' offices available outside the Skid Row area. Another proposal (33) suggests setting up a clinic for initial treatment including detoxification, and for referral. Since the clinic would be voluntary, both the initative to enter and the persistence to carry through with the treatment is "sufficient screening to assure high rehabilitation potential of those accepted."

The most innovative of the proposals is for a rescue service unit that would patrol Skid Row to find sick and acutely intoxicated men and take them back to the unit's quarters, or to hospital if necessary (47). The aim would be not only to provide homeless alcoholics with a place to sleep off their "drunk" but also to raise the general morality and image of the Skid Row area, and to provide the opportunity for self-rehabilitation. All members of the patrol unit, as well as the orderlies and maintenance staff of the residence would be sober Skid Row alcoholics who, through this type of social action of helping others, might themselves be helped.

Assessment of Program Results

Seven of the existing establishments give some numerical calculation of their results (15,32,37,39,43,50,51). The results of follow-ups on their clientele seem generally to be 'good' as compared to the estimate of the potential for rehabilitation by Mindlin in the study of a custodial institution (Washington, D.C. Workhouse) which cited 12 per cent as the successes to be expected from an unselected sample and 32 per cent from a group selected by

a scale of social and personal resources. Only the Detroit study fell below this (51). Others ranged from 29 to 80 per cent successes of their treated patients.

The evaluation of the results of the 5-year Alcoholic Rehabilitation Project carried out at the Salvation Army Men's Service Center in San Francisco (39) was made in terms of sobriety and work. Of 381 men, 28 per cent had remained sober during the follow-up of 6 months and 49 per cent of 337 men increased the amount of full-time work during the follow-up period as compared with the preadmission period. There was also a substantial overall increase in income, the number who lived in better housing and the number who reported better health and spirits.

In the case of voluntary treatment centres two important factors that affect results of evaluation studies concern (a) who has been treated - i.e. the personal and situational resources factor - and (b) at what point a patient is designated as entering the treatment program. The best results were obtained by counting as treatment cases only those who had attended 6 or more sessions and had signed an application (32). It is probably true of other programs that they don't count those volunteers who dropped out as soon as they found out what the program was like or at some other early stage. The lack of consistent criteria of success, together with the undefined and doubtful populations in some instances (37,59) compound the difficulty of accurate assessment.

Example of a Skid Row Institution

The Men's Shelter in Manhattan, N.Y. is an example of a voluntary, off-the-street institution for the Skid Row population. It is run and financed by the New York Welfare Department.

The aim of the program is to provide food and lodging for all Skid Row individuals seeking help and to refer them to various agencies for treatment or other assistance.

The Men's Shelter is housed in a four-storey converted Y.M.C.A. building in the Bowery and can accommodate about 400 men. The top two floors contain the sleeping arrangements - two double-bunk beds to a room - and the communal washrooms which at the time of inspection were not very clean. In general, the condition of walls, floor and ceiling is poor.

The second floor is used for processing the men who come in. The first floor contains the offices, meeting rooms, reading rooms and lounges.

In the basement are the 'drying out' room, the infirmary, the laundry, the dining-room and kitchen and a changing area where the men leave their clothes and are issued with pyjamas.

The staff comprises a superintendent, a case supervisor, clerks and 'detail' men who are selected from among the clientele.

On admission, if a man is very drunk he is sent to the 'drying out room' which is a converted gymnasium. Otherwise, he is issued a bed. If there are no beds available in the Center he is sent to a neighbourhood flop house.

The elderly, feeble and chronically ill are placed in institutions and some are referred for medical aid. If the inmate is considered to be a 'hopeful' case, he is referred to a welfare centre. If his is a drinking problem and he seems to have a good potential for rehabilitation, he is referred to Bridge House (a halfway house), to Alcoholics Anonymous, to an Alcoholism Clinic at King's College Hospital, or to Camp La Guardia, which is a farm run by the City of New York Welfare Department offering custodial care for the older and rehabilitation for the younger men.

The shelter itself offers no treatment program. It provides the immediate necessities of food and bed and sometimes clothing, and acts as a referral centre for those men with a 'hopeful' potential. The shelter also employs some of the more cooperative and active men to work in the kitchen, in the laundry and as floor supervisors.

Summary of Basic Ideas and Discussion:

Many of the Skid Row institutions are run by various charitable organizations, most notably and extensively, the Salvation Army. Anyone working with the poor as the Salvation Army has long done, and in particular working with homeless men, must have become aware of the problem of chronic alcoholism among the Skid Row homeless males. They have set up a great many Social Service and Harbour Light centres in numerous countries to attempt to deal with these men. Great emphasis is placed on the "spiritual regeneration" of the men who come to them, but also, varying from one centre to another, they provide residential and medical care, work, recreation, vocational and psychotherapeutic counselling. The chief emphasis in most of their centres is, however, on the spiritual rehabilitation of their clients, who are at the same time provided with work, board and lodging.

The programs set up by the municipalities tend towards being referral centres with or without residential care. The rationale here, as in the case of many of the proposals which suggest that the Skid Row institutions be used as referral points, is to use existing facilities which have been set up for the indigent and homeless as the most likely places to gather in chronic drunks outside of the courts and jails, and to use other facilities such as clinics, hostels, farm colonies, halfway houses, hospitals and job placement bureaus which are already in operation to deal with alcoholics or C.D.O.s or certain problems related to them. It has also been suggested that such a function would help to integrate all these separate existing facilities.

A further justification for not providing treatment but rather sorting out the volunteers as to their needs and referring them to the appropriate treatment facilities is that greater numbers can be dealt with in this way. This is undoubtedly true; in the past it has unfortunately been the case that very frequently not enough agencies or not a sufficient variety of facilities have existed to make sense of a good referral system.

However, no matter what the type of institution - mission, referral centre, clinic - and despite the fact that they have been set up or proposed to be set up in the Skid Row area specifically to accommodate the Skid Row alcoholic, they have not been noticeably successful with the particular group with whom we are dealing - the chronic drunkenness offender. Certain characteristics mitigate against success with the C.D.O. The problem is to reach these severely deteriorated, chronic alcoholics and then to encourage them to accept treatment. It is the voluntary nature of all these institutions which almost certainly precludes the majority of C.D.O.s with their notable lack of motivation. Even with the amenities of food and lodging provided, chronic drunkenness offenders frequently refuse to have anything to do with them. Unless there is a 'reaching out' effort on the part of the institution to recruit C.D.O.s, these institutions will have little effect on the hard-core, chronic alcoholic and drunkenness offender. The South End Center in Boston and the Neighbourhood Treatment Units suggested for Atlanta Georgia recognize this need for active recruitment, encouragement and establishment of rapport with these men.

Earl Rubington's scheme (47) is totally oriented to Skid Row and its homeless alcoholic and drunk population. It does not attempt to do away with Skid Row or get the men off it. Rather, the idea is to bring more order to the area, to allow the men to work things out for themselves, and to give a better image to one another and to the public. By its very nature it should reach almost all the Skid Row alcoholics. It is expected that a number of these men, by working hard at helping other Skid Row alcoholics, will maintain their own sobriety.

Many C.D.O.s tend to avoid the mission type of institutions, resenting the religious overtones. For instance, only one-fifth of our sample group of C.D.O.s had had any contact with the Salvation Army Harbour Light, which has been established in Toronto since 1955.

Screening for motivation for the sober or religious applicant, or the self-screening through a series of interviews, limits those treated to the more motivated, hence non-C.D.O. group. Ditman's theory that once alcoholics are over their withdrawal symptoms and medically fit they could then be treated individually in physicians' offices away from Skid Row, is unrealistic as regards the chronic drunkenness offender.

It seems paradoxical that Skid Row institutions set up in Skid Row to deal specifically with the Skid Row alcoholic should be unsuccessful with a large proportion of that particular population. But unless these institutions are geared to the unmotivated, homeless, chronic alcoholics, they have little effect on them for the simple reasons that they seldom make contact with them.

HALFWAY HOUSES

A halfway house for alcoholics is a residence which provides the opportunity for rehabilitation and a gradual transition from a closed institution to independent, normal living.

Halfway houses, or institutions calling themselves halfway houses, are the most numerous among the kinds of facilities which deal with the chronic drunkenness offender. In the C.D.O.'s case, the closed institution is usually a prison and the object of rehabilitation is not only his sobriety but also his resocialization into a different, more responsible way of life than he has been leading on Skid Row.

The paucity of detailed information on more than a few halfway houses, together with information from other surveys[9] leads us to doubt that all those included in our list actually qualify as true halfway houses; that is, as rehabilitation facilities to help persons re-enter society on an accepted, independent basis after having been institutionalized.

The proposals for this kind of facility are usually even less detailed as to structure and program than the descriptions of existing facilities. Some are only general statements of their purpose. A good detailed outline of suggestions is most likely to come from someone who has done a great deal of work with chronic drunkenness offenders and realizes the necessity to blueprint each phase.

Auspices - Existing

Of the 38 halfway houses reviewed here, the kind of organizations by which they are financed and administered are indicated for 20. Of these, six (6,27,28,41,43,120) are affiliated with such private charitable groups as the Salvation Army, the Oxford Foundation, Alcoholics Anonymous, and the Flynn Foundation. Seven (1,7,9,16,18,21,40) appear to be run by local

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[9] Lutheran Compass Center, California Survey

governments; three (3,19,35) by community councils or associations on alcoholism, or combinations of public and private resources (18,20,45,50). In Utah (5,64) the facilities have been independently incorporated but are co-ordinated with the State program.

Auspices - Proposed

In none of the proposals is it specified whether governmental or private organizations should run the halfway house. In 7 it is implied through the context that the halfway houses would be part of a co-ordinated court or custodial institution program in which they would be used as places for post-release support (8,10,44,46,48,51,52). Five indicate that the offender would continue to be under the supervision of an officer of the court, either a probation officer or a social worker, while in residence. One (8) would have a halfway house function in a "semi-protective, semi-custodial" manner. Two of the remaining 5 would have the facility modelled on the Compass Club (9) which, if taken literally, would mean private administration and finance and a voluntaristic control.

Four of the proposals suggest that halfway houses would be used solely to accommodate persons released from custodial or penal institutions (44,48,51,52). Another three (8,10,46) indicate they would be used for direct referral from court. In the three remaining cases the facilities would appear to be essentially 'Skid Row type' institutions, open to voluntary clientele and not officially co-ordinated with judicial or correctional facilities handling chronic drunkenness offenders.

Admission Process - Existing

Admission to a halfway house is by voluntary application in the majority of cases. For only 12 of the 38 halfway houses reviewed here is there sufficient evidence for us to infer that they accept alcoholics from jails(1,5,6,7,9,16,20,21,32,41,45,50). One is definitely for women C.D.O.s (32). We have sufficiently detailed information on another (9,54) to infer that only a minority come from this population.

As mentioned earlier, many of these institutions are actually halfway houses in name only, since they either do not take referrals from closed institutions or they provide nothing more than room and board for men with a drinking problem. Several appear to exclude men of 'doubtful' character or background. Such places might better be termed hostels or in-patient clinics. In fact, we can safely assume, unless it is specifically stated otherwise, that there is a screening procedure to weed out those chronic inebriates with an extensive record of social failure, partly because of limited facilities, and partly because of the propensity of C.D.O.s to 'use' such facilities for material benefits only.

Admission Process - Proposed

Among the proposals are three which advocate compulsory entrance into halfway houses; in one case the compulsory referral being from court (46) and in another a penal institution (8).

Four of the remaining 7 proposals (44,48,51,52) in which the halfway houses are also parts of complex programs, would accept referrals from custodial treatment programs.

Screening processes before referral to halfway houses are specified in all but 3 proposals. The purpose of the screening varies. One which suggests direct referral from court (46) specifies at least psychiatric screening; two would screen to separate the addicted from the non-addicted drinker (44,52). It is suggested in another (51) that the offenders be separated by their specialized treatment needs, i.e. need for treatment of tuberculosis or psychopathy.

Two proposals, instead of screening, would separate offenders either on the basis of their record (48) or by some kind of standard classification according to their drinking problems (8). How this division of offenders, which is made for purposes of treatment, is related to admission to halfway houses is not indicated.

The social worker or parole officer would plan for post-release social rehabilitation of the C.D.O. in two of those proposals which suggest halfway houses as part of larger programs (51,52), although we are not told what the conditions for inclusion in a halfway house would be.

The remaining proposals (49,56,58) give no indication of admission procedures, although they are all oriented to the Skid Row drinker.

Duration

The oldest facility, in our survey of the literature, is Bridge House (21), which was opened in 1943. The others for which dates are given were opened during the 1950's. Two others (3,5) were proposed in 1962 and 1957 respectively. Twenty-two were presumably in operation in 1958, when they were reported to the Governor of Massachusetts by H. N. Demone Jr (17). The literature on the remaining three (6,45,47) indicates they were in operation in 1957, 1960 and 1960 respectively. We do not know if any have ceased to operate.

Dates and Backgrounds of Recommendations

The 1950's was the decade in which halfway houses chiefly came into existence, and 8 of the 10 recommendations come from that period. One (8) comes from the 1940's and one (44) from the 1960's.

The majority of the proposals were made by persons or groups who have done a lot of research into the problem of the chronic drunkenness offender (44,46,51,56,57,58) such as the Emory University Department of Psychiatry, which has made an intensive study of the C.D.O. situation in Atlanta. This lengthy report proposes a multi-aspect system, including a court-clinic antabuse program, a treatment centre for both in-patient and out-patient care,

neighbourhood centres in Negro slum areas normally out of the reach of the other aspects of the system, a custodial farm treatment centre for both voluntary and compulsory committals, and a halfway house.

The remaining research-oriented proposals come from: The Detroit Mayor's Committee on Skid Row problems (58). alcoholism foundation administrators (8,56); and two sociologists (51).

In the 4 remaining proposals we find two reports of conferences on the C.D.O. problem (49,52), a report of a community alcoholism council to its county government (48) and a report on the Danish system recommending improvements (10). This latter proposal, though not extensive, adds to the already quite intensive Danish system, that includes a forensic clinic within the police department which is called into action whenever a public disturbance is created by abnormal behaviour. This covers C.D.O.s, of course, who may be referred to hospitals or out-patient clinics but are more likely to be given intensive social work treatment. The present proposal suggests that psychotherapy and a halfway house program could be fruitfully added.

Treatment - Existing

Sixteen of the halfway houses on file[10] give some description of a treatment program for rehabilitation over and above bed and board. In 4 of these the central therapeutic service seems to be religious conversion; three by the A.A. philosophy (9,21,39) and one (6) by the Salvation Army. Five others (5,16,20,32,45) use A.A. as part of a multi-faceted program. Only two (16,50) use drugs to help their clients maintain sobriety. Eight of the 16 focus on social rehabilitation and employment for their clients (1,5,7,9,16,45,47,50).

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[10] The ARF Halfway House at 10 Madison Ave. was not in operation at the time of the original review of the literature and has not been included here. The reader is referred to the ARF Substudy, Informal Service - Research Report: Seaton Unit and 10 Madison - Summer 1971, by C. D. Webster, Janet Oki, B. Garrett and B. Peterson.

Some have professional staff who offer specialized therapeutic services. Three (5,41,50) provide medical aid. Five give psychiatric aid through group or individual counselling (5,9,16,39,50). One (50) has no limit as to length of residence; 4 (7,9,16,45) have limited residence duration varying from two weeks to two years.

The standards of expected behaviour vary in the different establishments. In some cases the men are not allowed to remain if they begin to drink again. In four of the houses (9,16,45,50) relapses are not grounds for eviction and rigid sobriety is not always expected or even the goal, (16,41,47) where individual potentials are taken into consideration.

No description of treatment is found for 20 of the halfway houses.

Treatment - Proposed

Those who propose halfway houses for alcoholics do not see them primarily as alcoholism treatment centres. They are usually suggested as part of larger programs in which treatment is given elsewhere. Their function is considered to be to support the individual in his first attempts at undertaking a sober, more normal life. Programs are suggested only vaguely in such general terms as "gradual programs of rehabilitation" (8);"gradual restoration from the institutionsl 'crutch'"(51);"gradual transition in some cases requires halfway house" (52).

Two which give some indication of a program suggest they should be modelled on the Compass Club (48,56).

Perhaps understandably because of the type of institution it is, there is more concern about how the halfway house should be organized internally. At one extreme are those who advocate 'self-government' by the inmates; at the other those who suggest supervision by persons legally authorized to use the threat of punishment for failure to conform to the standards. Two would have control maintained by using probation as a threat (51,52)

and one would use suspended sentences (46). Bacon (8) suggests halfway houses should be 'semi-custodial', a term he leaves undefined.

Such significant aspects as length of residence regulations, and qualifications for re-admission, are not specified except in one case (52) where it is suggested that the period of residence might be indefinite for some persons who appear incapable of leading an independent life.

In two other cases (48,56), if their acceptance of the Compass Club model is taken seriously, it would mean having a 6-month residential treatment program with the possibility of re-admission up to two times after a 'slip'.

Assessment of Results

There is evaluative material in the literature on 4 of these halfway houses only: the Boston Long Island Hospital, the Belmont Rehabilitation Center of Worcester, Mass., Bridge House, New York, and the Compass Club, New Haven, Conn.

The Boston Long Island Hospital has conducted a long-range follow-up of some of its patients. Myerson reports:

> Of 100 men who attempted this program 12 of them had not only achieved complete sobriety for three years but had also managed to re-establish themselves successfully in a family structure of their own. They no longer were wards of the city, but had become self-sufficient members of society. A group of 42 men showed considerable improvement in their drinking patterns, worked more or less consistently in relatively productive work, but basically remained dependent on our structured community. These men were successful as long as they remained in the hospital, but they consistently failed outside. Most significantly, despite all the help offered them, they were not able to become members of a family unit. This observation is important. (50)

The Belmont Rehabilitation Center (16) reports that of 78 admissions, 61 were resident in 1959, 27 'unchanged', 23 were employed, 6 employed in day labour, and 11 were maintaining employment, or with their families, but drinking to a certain

extent, over a 5-year period.

Bridge House, New York (21) used the criterion of total abstinence as the measure of success. Of 325 former residents, 52 were abstinent at the time of assessment.

A study was made in 1962 of the men who had been admitted to and left the Compass Club during the year of 1960. Although 46.7 per cent had been discharged for disciplinary reasons, usually drinking, 75 per cent of the total study population showed marked improvement where such things as employment and sobriety were concerned. Seven per cent showed no change and 18 per cent showed some over-all deterioration.

Example of a Halfway House - The Compass Club

The Compass Club, as we have noted above, has been frequently cited in the literature as a halfway house worthy of emulation. For this reason, and also because it has been thoroughly studied, observed and reported on since its inception, we will examine its functioning in detail.

The Compass Club was established in New Haven, Conn. in 1956. It is operated under the auspices of the Alcoholism Division, Connecticut State Department of Mental Health. Funds ($60,000) were appropriated to the Commission on Alcoholism by an Act passed by the legislature in that year.

The aims of the program are two-fold: firstly, to select chronic drunkenness offenders for study, care and treatment. Secondly, to study factors relevant to and connected with the problem of chronic drunkenness offenders.

The Club is housed in part of a 3-storey building leased from the Yale Hope Mission, in a Skid Row area of the city.[11] The Club's quarters are separate from the Mission which occupies the same building.

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[11] In 1966 the Compass Club moved to its own building, a 36-bed unit, in Hartford, Conn. Because any studies referred to were carried out in and on the old premises, we present the description as it then was.

On the third floor is a 10-bed dormitory; on the second floor are 14 private rooms to which the men 'graduate' as openings occur. The dining-room and lounge are in the basement and offices for the counsellors are on the first floor. The Compass Club is entirely within-doors; there are no outside facilities.

The staff comprises a Supervisor, four consellors and a research sociologist. The counsellors are all recovered alcoholics and members of Alcoholics Anonymous. They are employees of the State and listed as "therapy aides" in the State Personnel Classification system.

Membership capacity is 24 at any one time. To become a member, a person must be a resident of Connecticut with an arrest history of three or more arrests for drunkenness in the past five years. He must fall within the 30-55 years age group, be employable (physically and mentally) and, of course, express the wish to gain sobriety by methods of the Club's program.

The Club acquires its members through referral chiefly from the State jail, the Blue Hills Hospital, and from self referrals. Other sources are such agencies as Alcoholism Division clinics, A.A., Missions, court officers and clergy. Membership is entirely voluntary.

The treatment program lasts six months. Upon admission, the member is interviewed by the Supervisor, the program is outlined to him, he is given a medical examination and is assigned to a counsellor. During the first week, which is free, the member must try to obtain outside employment. After that, he is required to pay up to $3.00 a day in 'dues'. There are two evening meetings a week which the individual is encouraged but not forced to attend. One is a general meeting for all members, the other is with the member's own counsellor. All aspects of problem drinking are discussed both in the public meeting and in the frequent private discussions with fellow members. One counsellor sleeps in the Club every night to be available for consultation.

Completion of the program is the major goal although members do leave before that for their own or disciplinary reasons. Members are permitted to enter the program a maximum of three times.

This living and working and being treated together in a group under conditions combining features of a men's club and a convalescent home is a major part of the treatment. It enables the men to enjoy the give-and-take of normal group experience in a semi-protective environment, and to shift dependence on alcohol and on his former drinking group, onto the Club.

Follow-up on 28 men who were admitted to and left the Club in 1960 showed 75 per cent with some or much improvement, 7 per cent with no change over-all, and 18 per cent deterioration. Improvement was rated in 6 areas: living arrangements, employment, health, family relationships, other social contacts, and drinking.

Summary of Basic Ideas on Halfway Houses

Halfway houses became almost a fad of the 1950's: halfway houses for alcoholics, ex-convicts, drug addicts, former mental hospital patients, all deviant groups of some kind trying to make it back to normal society. They came into being because it was realized that to thrust a person out of the dependent situation of a large institution such as a mental hospital or jail and leave him or her to find his way in the world unaided and alone, was a sure way of sending him back into the hospital or jail. Halfway houses appeared to offer a panacea for many ills. They would be a bridge between two ways of life, supply a family atmosphere, provide a buffer against the harsh realities of society, and at the same time attempt to rehabilitate their clientele.

> The half-way house, as the name implies, is a facility which bridges the gap between penal and other large institutions and the community. It makes the assumption that certain individuals can best be rehabilitated if their return to the community is gradual rather than abrupt. Its aim, starting with sobriety, is gradually to introduce the men to jobs, independence, and respectability

> in the community. In the process of achieving this aim, the men also gain or regain a sense of pride, self-respect and a will to live.
>
> (11, p.19)

They seemed particularly suited to the needs of the extreme deviant drunkenness offender, who more than most is without a home or family or resources of any kind. In the halfway house he would receive the support of a group while he adjusted from the dependency of the jail routine and his former Skid Row way of life to an independent, working situation.

The enthusiasm with which the halfway houses were launched was not matched with sufficient understanding, backing or long-range planning if we can judge by the fuzziness of aims, the paucity of treatment, the almost total lack of study, follow-throughs and evaluation of their overall worth. Indeed, their function seems vague even to those who propose their use.

On the whole, this is a facility which is working out its shape and purpose empirically, so that suggestions and proposals must, or should, come after the event.

It was not until the next decade that a thoughtful re-assessment took place and, in 1966, a First North American Conference of halfway house alcoholism programs. At that time planners and those in charge of existing programs began to take a long look at the aims, the structure, the staff and the clients of halfway houses and to sum up the experiences and mistakes over a period of years.

To begin with, it was seen that halfway houses should not be expected to provide a complete solution to the problem of chronic drunkenness offenders but should only be one link in the rehabilitation chain.

> Half-way houses probably can never be more than narrow-range institutions with strict behavior expectations, although within their range, they can provide an extremely valuable function. No type of service can be all things to all men, and none should try, but neither should a community

> expect any single type of agency to serve the broad range of needs of the different kinds of problem drinkers. (13, p.16)

How much should the halfway house be expected to provide? What, in short, are its functions?

There is general agreement that it should be a supportive residence, providing the client with a substitute family. It should also provide him with continuing therapy and counselling while he makes this really tremendous step towards sobriety, employment and independence.

"The halfway house," says one executive director of such a facility (53, p.70)"must succeed in providing a warm and satisfying group experience and, at the same time, include an element of challenge."

However, many C.D.O.s coming directly from jail are not ready for such a giant step, nor able yet to face a challenge. As Leonard Boche says, in discussing Granville House, a halfway house for women alcoholics:

> ...it is necessary before a resident can fully benefit from the kind of support that a house such as Granville House provides that there must be significant previous treatment (12,p.51).

Therefore, to be effective as a step in the rehabilitation of the chronic drunkenness offender, the halfway house should be part of a program, not the whole program; it would still be a bridge but not the only one between the jail and the outside world - and not the first bridge. The aim is to give support - both individual and group support - while the person meets the challenge of finding a job, working among people he does not know, and at the same time remaining sober. But prior to this he probably needs a period of occupational and psychotherapy of some kind, free of the strains and fears and responsibilities which come with working in a society from which he has so long been alienated. It is those very strains and fears and responsibilities

which contributed to his becoming a Skid Row problem drinker. To reverse the process of many years will take more than supportive therapy in a halfway house.

Since one aim of the halfway house is to provide this substitute family and support (or a substitute for Skid Row relationships), the structure and staff become important. It should be small, accommodating no more than 25 clients (55) or even fewer (53) so that the staff can get to know their clients; so that institutional rules and regulations can be kept to a minimum and so that "rehabilitation might be attempted on the 'family plan'." (53, p.67)

A further important point has been raised by Boche (12). The halfway house is not a closed institution cut off from the rest of the world, and therefore "...one of the most vital elements in any program is the relationship to the rest of the community." The author does not refer only to the linkage with other social institutions and professional bodies such as social work agencies, alcoholism clinics or A.A., but with the men and women of the community, potential employers and actual neighbours. Work must be done to make the halfway house and its inmates an accepted and acceptable part of the community.

Finally, Rubington points out (55) a really crucial factor in the success of halfway houses, and that is the importance of measuring results. In spite of the numerous halfway houses in existence, there is little information on their functioning and few data on their results. Without these, comparisons cannot be made nor the efficacy of halfway houses truly estimated. And unless there is constant vigilance and re-assessment "...the halfway house degenerates to being just another revolving door through which the alcoholic-dependent passes on a road strewn with numerous institutional adjustments." (53, p.70).

MENTAL HOSPITALS

We define mental hospitals, for purposes of this study, as those institutions that accept alcoholics as patients under the sanction of civil commitment similar to commitment for the mentally ill.

In the past few decades mental hospitals have come to be used for the treatment of alcoholics with increasing frequency. "Mental hospitals are now taking a greater share in treatment of alcoholics than ever before," Ferguson wrote in 1956 (4, p.326). In Ontario this increasing use of mental hospitals is noticeably a post-war phenomenon as shown in a comparison made by Popham of the rate of first admissions of alcoholics to mental hospitals from 1946 to 1953. Over that 8-year period the rate increased 247.2 per cent (12).

The reasons behind this trend seem apparent enough. It is only in recent years that there has been a shift in emphasis from a moral judgment on drunkenness to the disease concept of alcoholism (with a parallel change in terminology from 'drunkard' to 'alcoholic').Nevertheless, although drunkenness was considered to be morally reprehensible, it was also considered to be either a form of insanity itself or the cause of numerous forms of insanity (5). "Even now," Haggard and Jellinek wrote, in 1942, "in some institutions for the care of the mentally ill, there is an inclination to diagnose any mental disorder connected with drinking as an "alcoholic psychosis""(5, 218). Further, they suggest a

> ....close association which, in popular opinion, has always existed between drunkenness and mental disorders. The irrational behavior seen in both acute intoxication and insanity made for ready belief that frequent drunkenness would result in permanent derangement of the mind. The association was supported by a feeling of moral justification; insanity seemed a fitting end to the Rake's Progress.
> (p.216-217)

If drunkenness was considered a form of insanity, why was it not treated in insane asylums? To begin with, the insane were not 'treated' but rather were punished, and the same punishment was handed out to drunkards. As a different conception of mental illness and its treatment arose, presumably a differentiation between mental illnesses and drunkenness took place. Drunkenness continued to be punished when openly exhibited and, of course, still is. The law has not caught up with medicine.

However, for those alcoholics who did not come up against the law, and for those unable to enter specialized private clinics, mental hospitals were for some time the only places for treatment. This does not explain why alcoholics are entering mental hospitals in ever increasing numbers. There is no doubt that with greater prevalence of private and public hospital insurance and a variety of other factors, there is a general trend towards hospitalization, of which this may be a part. Yet none of these seemingly apparent reasons accounts for this tremendous increase, according to the conclusions drawn by Popham from his statistical survey of admissions to Ontario mental hospitals. "...the postwar increase in admissions for alcoholism cannot be fully explained on the basis of increased prevalence [of alcoholism], as a reflection of a general trend, change in attitude, or alteration in basic facilities"(12,p.5). Possibly the cumulative effect of all these factors, along with increasing social pressures of family, doctor and social agencies to maintain standards, and together with the fact that mental hospitals provided until recently the only haven for alcoholics who were not wealthy enough for the private sanatoria nor destitute enough to be picked up by the police, add up to create this effect.

In spite of this general trend, the number of chronic drunkenness offenders who find their way into mental hospitals is very small. The reasons for this are not hard to find.

Patients may either volunteer for admission to mental hospitals (that is, they are 'self-committed') or they are committed under civil law for admission as alcoholics by relatives or other interested persons. Both are inhibiting factors to the C.D.O. To begin with, very few C.D.O.s voluntarily apply for treatment help of any kind. And since the chronic drunkenness offender has few friends or relatives with whom he has contact any more, he is not likely to be committed by them. Even the physical difficulties of getting to a mental hospital which is most probably far from Skid Row and thus less available than Skid Row institutions, make self-commitment unlikely. If the geographical barrier is overcome, the psychological one, of committing himself to a mental hospital, is almost insuperable.

The admission figures for inebriates at one State Mental Hospital (16) during a one-year period is 9 per cent of a total of 3,000 admissions. Of these 270 persons, if we consider their employment record and various social factors, we would have to say that a maximum of one-third could be considered Skid Row chronic drunks.

Interestingly enough, the trend towards increasing use of mental hospitals for treatment of alcoholism does not have a parallel trend in the literature on proposed methods of treatment. This discrepancy between fact and theory may indicate that mental hospitals are indeed used simply for lack of better, or other, accommodation.

Only 5 of the proposals make reference to mental hospitals as possible treatment centres for persons suffering from alcoholism or severe drinking problems (4,6,7,8,15). Only one (15) of the 5 proposals would have problem drinkers treated in mental hospitals as they now exist. The remaining 4 suggest that alcoholics should rather be treated in similar custodial institutions specializing in treatment of alcoholism.

These proposals are not primarily concerned with chronic drunkenness offenders as such.

Auspices - Existing

The institutions are all under the jurisdiction of provincial (or state) or national governments (the latter in Europe). In North America they are very frequently called 'State' or 'Provincial' hospitals.

Auspices - Proposed

The various proposals all assume that mental hospitals for the civil commitment of alcoholics would remain under the present level of government administration.

Duration

The German abstinence asylums apparently go back to the 1920s, and the use of mental hospitals to treat chronic alcoholics in the U.S. is quite an early form of rehabilitative attempt. One, (17) Binghampton State Hospital, as early as 1868 treated alcoholics using methods of persuasion through "affection and inspiration." The beginning dates of these civil commitments are stated for four institutions. These dates are 1935 (18), 1945 (9), 1927 (1) and 1950 (13). No indication is given of the termination of any of these programs.

Dates and Background of Proposals

The oldest of these proposals originated in Germany in 1926. This plan suggested definite periods of enforced abstinence for alcoholics. Probably on the basis of this proposal Ellikon (1) and another inebriate asylum were opened the following year, although both were, in fact, voluntary.

The remaining proposals originated in the U.S. or Canada and were published in the 1950's. M. L. Selzer's proposal (15) is based on studies he carried out of alcoholism inmates in Michigan's State Hospitals and this author has elsewhere proposed compulsory treatment for those alcoholics who come into conflict with the law.[12]

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[12] Selzer, M.L., "Alcoholism and the Law. The Need for Detection and Treatment." Michigan Law Rev. 56: 237-248, 1957.

Admission Processes - Existing

In North America the general procedure is for patients to enter these institutions by civil commitment under the laws covering the commitment of persons for mental illness. In one hospital (18) persons are committed as psychotics even though they are not so diagnostically. In Germany in 1927 (1,2) it was possible to commit individuals to special "abstinence sanitoria" for severe alcoholism.

Admission Processes Proposed

Three of the proposals (4,7,15) specify that treatment should be compulsory for 'some' alcoholics, but do not indicate which ones, nor how they would be screened. A European proposal (7) implies that compulsory commitment would follow on the individual's behaving in such a way as to be dangerous to himself or his dependents.

The other two proposals do not indicate directly how a person would be brought in for treatment but suggest that 'chronic' alcoholics should be separated from 'psychotic drinkers' for specialized treatment (6,8). The psychotic drinkers are apparently diagnosable as having certain ascertainable psychic maladies and therefore should have psychiatric treatment in an asylum; chronic alcoholics should be admitted to a custodial treatment setting if they fail to respond to mental hospital-like treatment (8).

The underlying admission procedure into the mental hospitals, or facilities similar to mental hospitals, which distinguishes them from other modes of treatment is the use of civil commitment rather than criminal action. One plan (4) proposes specifically that alcoholism be treated as a problem in public health, as tuberculosis and mental illness are. This would necessitate the facilitation of processes of civil commission to accommodate 'resistant alcoholics' amongst whom might be included the chronic drunkenness offenders.

Treatment - Existing

The characteristic treatment for alcoholism at present in mental hospitals is 'enforced abstinence'. In two (3,13), the period of enforced abstinence is 60 days and in one (1) it is a year. One hospital (9) apparently has some form of psychotherapy; two (14,16) offer occupational therapy, AA groups, group psychotherapy and counselling (14), as well as bi-weekly or monthly interviews by the ward psychiatrist (16). The most extensive treatment is given in Willmar State Hospital (Minn.) (13), which specializes in treatment of inebriates. Treatment begins with the use of drugs, intravenous feeding and sleep until the patient has 'dried out'. Then he is given an orientation course of 28 hour-long lectures on alcoholism and its problems; individual and group psychotherapy and psychodrama from a staff of counsellors, chaplains and psychologists. A further important adjunct to the program is their Follow-up Clinic, which attempts to act as a bridge between the hospital and the community. In particular it refers the patients to outside resources, especially to AA.

Treatment - Proposed

Of the recommendations for mental hospitals, only two (8,15) indicate a specific treatment program beyond 'enforced abstinence'. One of these (15) suggests psychotherapy, education, AA meetings and 'medication which is psychologically beneficial'. It is also suggested that the inebriate be hospitalized immediately after the drying-out treatment, so that he is still suffering withdrawal symptoms and must therefore acknowledge that he needs help. Moreover, he will appreciate the help he receives from the staff at this difficult time, thereby lessening his resistance to them. A further aspect of this suggested program is a short (2-month) definite custodial period to give the patient a 'therapeutic goal'.

The other detailed program (8) is aimed primarily at severe chronic alcoholics who have failed a number of times in a number of programs. These persons would be committed to an

indefinite period of custodial supervision on a farm or in a work colony. Treatment would be very mental-hospital oriented and might include psychotherapy, analeptic shock, conditioned reflex and even lobotomy.

Assessment of Results

The German abstinence asylum (1) presents data for the longest follow-up: 19 years. These data show 33 per cent abstinent, but since a 2-year follow-up in 1932 indicated only 15 per cent abstinent, one wonders about the follow-up procedure, especially considering the intervention of World War II.

Five American mental hospitals present quantitative data on their results. These show 37 per cent improved in a 4-year follow-up (18); approximately 45 per cent improvement with 6 totally abstinent in a 6-year follow-up (3); 35-42 per cent improvement - no length of follow-up mentioned (16); and one-third sober, one-third drank less (14) in a 3-month follow-up.

In Minnesota, where the treatment is extensive, a follow-up study over 5 years showed that 30 per cent of the released patients were abstinent and 21 per cent were motivated and improved. The researchers realize that there is no necessary cause-and-effect between the program and subsequent improvement, and indeed suggest that AA, to whom many of the patients are referred, contributes much to the improved and motivated groups.

Another follow-up study (9) concludes that treatment "under duress" even for persons who do not want to stop drinking or who do not consider themselves alcoholics, can be fruitful. Of those patients who claimed they did not want to stop drinking, 37 per cent remained abstinent more than one year. Fifty-nine per cent of those who considered themselves to be alcoholics, and fifty-three per cent of those who did not, remained abstinent for at least one year after release from hospital.

Of 228 patients discharged over 7 years from Binghampton in the 1860's, 50 per cent were considered 'permanently reformed' (17,p.718).

The results indicate some substantial success with persons who are most likely severely addicted to alcohol, in a compulsory treatment program. The improvement rates do not seem to vary a great deal whether treatment is extensive or merely consists of a long-enforced period of abstinence, so that other factors (such as the influence of family or employer) may enter into the picture.

Any success or failure of these institutions probably has little relevance to our study because they deal with so few chronic drunkenness offenders.

A Brief Summary of Basic Ideas

Mental hospitals have come to be used more and more for the treatment of alcoholics. The recommendations reviewed here are based on the idea of using existing facilities as an economic measure but designating certain mental hospitals specifically for the treatment of alcoholism (4,15). This would obviate any stigma attached to entering a mental hospital. Patients would be admitted through civil commitment, which would avoid adding to the difficult social situation of the alcoholic the burden of a criminal record and the need to be considered a criminal before he could be treated. Presumably such a hospital would receive all kinds of alcoholics (although it is suggested that alcoholics with psychoses be treated in regular mental hospitals) from all classes. Certainly two of the proposals (8,15) appear to have the C.D.O.s in mind since they suggest getting the inebriates immediately after 'drying-out' in one case, and taking those who have failed to respond to treatment elsewhere, in the other. In both cases, C.D.O.s would be likely candidates.

The justification for the use of this type of custodial treatment is the belief that compulsory treatment is necessary for some alcoholics: the severe cases, the 'resistant' alcoholics and those whose behaviour could harm others and themselves.

Selzer points to evidence that 'unmotivated' alcoholics can be motivated toward treatment in this type of setting (15). Unmotivated alcoholics or problem drinkers, and alcoholics who do not perceive themselves as such are not likely to be treatable without such control.

It is not suggested that all problem drinkers need this kind of compulsory hospitalization but only those who are not aware of their own condition or who, being aware of it, are unable or unwilling to control their own behaviour. Certainly a great many chronic drunkenness offenders would fall into these categories and therefore, where few at present are treated in mental hospitals, under such a system many more would receive this involuntary treatment.

Perhaps the most important or interesting aspect about this system is that it is another way of dealing with alcoholics - neither voluntary nor criminal, but subject to civil action.

DETOXICATION CENTRES

Throughout this review of treatment centres for public drunkenness offenders, a trend emerges in the philosophy accompanying and directing recent developments. As alcoholism has come to be considered less of a legal issue and more of a medical one, public and chronic inebriation is gradually being recognized or considered as a public health issue rather than a criminal one.

During the past decade legal recognition has occurred in some jurisdictions of the United States as evidenced through certain legal rulings concerning the disposition of chronic drunkenness offenders. In some States conviction of a chronic alcoholic for the crime of public drunkenness is now considered a violation of the Eighth Amendment of the U.S. Constitution as being "cruel and unusual punishment." In other States, following upon the decision in the Easter v. District of Columbia court case, chronic alcoholics are held to lack the criminal intent which would make them criminally responsible for being drunk in public. Although the Supreme Court more recently (1967) upheld the conviction of Leroy Powell (23), arrested for the 100th time for being drunk in a public place, part of the reason given is the lack of any alternative to jail as a sobering-up place for homeless inebriates. In spite of this decision, which overrides Easter and other decisions by federal District Courts, the trend is towards change and reform in public drunkenness laws.

In Canada, a person who causes a disturbance by being drunk in a public place is guilty of a punishable offence under the Criminal Code (Revised Statutes of Canada, 1970,Ch.C.34,sec.171,(ii)). Every province except Quebec also has a law prohibiting public drunkenness, with a fine or imprisonment as the penalty for contravening the law. In Quebec, public drunkenness comes under the jurisdiction of the municipal government. However, in Canada, too, there is a general trend towards law reform at both the Federal and Provincial levels. Most provinces have already modified the statutes concerning the handling of public

inebriates. The offence of being intoxicated in a public place has remained on the statute books but the police are given discretionary authority for taking an intoxicated person into custody.

This change in attitude towards public intoxication gives rise to the question of what further legal action is going to be taken, when it will come about, and what preparations and methods we will have for handling a problem that will still exist no matter within what context we view it.

Since 1967 a new type of service has been experimented with in a few metropolitan centres in the United States and Canada. This is the alcoholic detoxication[13] unit which is under consideration as an alternative means of dealing with public drunkenness offenders who are subject to arrest and incarceration under present legal rulings.

The literature so far describes 5 such units in North America. These have been set up in Washington, D.C., New York City, Baltimore, Md., St. Louis, Mo., and Toronto, Ontario. Evidentally there were already established in Europe, notably Czechoslovakia and Poland, somewhat similar units called "anti-alcohol" or "sobering-up" stations (10,28).

Thus far the detoxication centres have been undertaken on an experimental basis.[14] Their primary purpose is to treat acute alcoholic intoxication. All of them have a research component since the method is a new one and seems to be approached with more caution, planning, and self-analysis than most treatment modalities.

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[13] We use the term 'detoxication' rather than 'detoxification' and shall refer to these treatment modalities as such unless referring to a specific unit.

[14] Other detoxication centres have undoubtedly been established by now, possibly in Kansas City, Mo., Des Moines, Iowa, and Chicago, Ill. (28) as well as two in Toronto. We have been unable to find descriptive material in the literature on them.

In the Baltimore Center the emphasis is on research into various treatment methods for alcoholism (12). In St. Louis the stated goals are to determine how much time such an agency would save in police man hours and to evaluate the effectiveness of short term treatment procedures on the public intoxicant (8). Those responsible for the Manhattan Bowery Project wished to discover whether Bowery alcoholics would accept a voluntary program of alcoholism treatment and referral to other types of programs, and whether such a program would work in a non-hospital setting (11). In Toronto an expressed goal is "to gain an impression of the resources and facilities necessary to close the "revolving door," to test community resources for referral and after-care, and to discover what staff and equipment are necessary to furbish detoxication centres most effectively and economically (18, p.3). Both Toronto and Washington expressed as a further goal the experimenting with a public health approach while still within the present legal system. Besides providing an efficient sobering-up method for intoxicated persons, the Washington Center is intended to help patients recognize problems associated with drinking and to help them obtain medical, psychiatric, and social services (25).

Auspices.- Four of the five mention the sponsors of the programs and the source of the funds for implementing them. The Baltimore unit is located within the Provident Hospital and is under the supervision of that hospital's Department of Medicine. Washington's Alcoholic Detoxification Center was set up under the sponsorship of the District of Columbia Health Department with a 2-year grant from the U.S. Department of Justice for the initial operating expenses. Since 1970 it has operated under the Department of Human Resources of the District of Columbia Mental Health Administration. St. Mary's Detoxification Center in St. Louis (later called the St. Louis Detoxification and Diagnostic Evaluation Center), under the auspices of the Police Department, also received a grant from the Department of Justice which was supplemented by funds from the City of St. Louis and other contributions, including the nursing services of the Sisters of St. Mary. The Manhattan Bowery Project is a collaboration of public and private

agencies. Instituted by the Mayor's office with the assistance of 18 community agencies, funds came from the New York State Department of Mental Hygiene, the Vera Institute of Justice, and the City of New York's Community Health Board. Toronto's Detoxication Unit was set up and funded by the Addiction Research Foundation, which is an agency of the Province of Ontario. The anti-alcohol stations in Czechoslovakia are under the ultimate direction of the Ministry of Health. The Polish centres, of which there are 20, are administered by the municipal authorities under the central control of the Ministry of the Interior (10).

Duration.- The St. Louis unit was opened in November 1966; the Baltimore, Washington and New York units were opened in 1967; the Toronto unit in 1968. Most have either ceased, re-located or changed in some other way. The St. Louis Center was relocated from St. Mary's Infirmary to a ward in the St. Louis State Hospital as a permanent treatment facility in January 1969. The Detoxification Unit in Washington was removed from the hospital area to its own building in 1968. The Toronto Unit, which was a pilot project, ceased to function in 1970, although the ARF subsidizes a Detoxication Unit of 10 beds subsequently set up in Seaton House (a Skid Row hostel for men) which is not, however, solely for police case inebriates. Another 16-bed unit opened in 1971 in Toronto. In Prague the first drying-out centre was opened in 1951 and in Warsaw in 1956.

Cost.- Four of the five detoxication centres state the daily cost of caring for patients in their units. The District of Columbia Unit had the lowest cost at $20.75 for each patient daily. The other reported costs were: Manhattan Bowery Project $38.00; St. Louis $42., and the A.R.F. $55.

A closer look at this wide variation in the operating costs of essentially similar units is warranted in view of recent Ontario Government decisions to establish such units in Metropolitan areas and a general trend towards their establishment in North America. It is also of interest to compare the relative costs to the community of the detoxication approach with those

of incarceration.

The cost per capita appears to vary with the number of admissions and with the professional make-up of the staff. The District of Columbia, with 50 beds (eventually 75), had 10,842 admissions in one year. St. Louis, on the other hand, had 30 beds and 1,120 admissions. The A.R.F. had 22 beds with 1,586 admissions (over an 11-month period), and the Manhattan Bowery, also with 50 beds, had 3,000 admissions. The last three had full-time physicians, and St. Louis and the A.R.F. had a Medical Director. The District of Columbia Unit gave essentially nursing care, with only a part-time physician on staff. With that ratio of admissions to beds it also meant a considerably shorter stay in the Washington Detoxification Unit: 2.2 days average, compared to 7 in Manhattan, 5 in St. Louis and 4½ in the A.R.F.

The report on the A.R.F. Detoxication Centre suggests that the Director should not be a physician, that a full-time medical staff is not necessary since very few cases require medical attention other than detoxicating, and that the physical examinations given are not necessary or very useful considering the lack of follow-through with these patients. The estimated cost of a 22-bed Detoxication Centre contained in a hospital ward with optimum staff requirements is $36.88. However, with more beds and shorter stay and therefore a greater number of admissions the cost should be reduced even more (presuming no other factors accounted for the much lower rate in Washington than in St. Louis, New York and Toronto).

In Toronto, the cost of keeping a man in the Don Jail is approximately $8.00 a day - less than a quarter of the cost of detoxifying him. This is an unrealistic comparison since it does not take into account 'hidden costs' of jailing a person. We do not have the figures on the amount saved in terms of police hours, Magistrates' time and other Court costs. We do have an estimate of these figures from the Police Department in New Orleans, where the daily jail cost is very similar to that of Toronto at $8.20. Brisolar et al. (6) estimate the cost of pick-up and disposition at $30., but even this does not include

municipal Court costs and medical services.

Admission Procedures

The St. Louis and Toronto units are strictly for persons arrested on public drunkenness charges, who are taken to the unit instead of the jail by the police (in the Toronto ARF Unit during the last 6 months of its existence, a 10-bed ward was set aside for female drunkenness offenders. Seven per cent of the patients in the St. Louis Center were female.) The two recently established Toronto Units, however, are voluntary and accept referrals and off-the-street admissions. The Washington Center accepts voluntary applicants and men who are brought in by A.A. or relatives, (35 per cent of the total admissions),referrals from other agencies, (15%) as well as persons arrested for public drunkenness (50%). To be admitted, patients must agree to cooperate with the staff and the program. In New York, a two-man 'rescue team' patrols the Bowery picking up ill and intoxicated males and taking them to the Unit where admission is, however, entirely voluntary. Admission to the Baltimore Center is voluntary and requires referral from a physician, A.A., the clergy, or some other official person or body.

Polish and Czechoslovakian centres accept voluntary admissions as well as public drunks brought in by the police (frequently in an ambulance). Emergency treatment for the police-referred admissions is compulsory, and a fee is charged the person on leaving (28).[15]

Length of Stay

The length of stay averages 4 to 5 days in Baltimore, with a maximum of 10 days; up to 7 days in the Bowery, with an average of 5.5 days; 3 to 5 days in St. Louis and a maximum of 5 and 7 days respectively for Washington and Toronto - although Washington, because of overcrowding, had to reduce the maximum to 72 hours. In the A.R.F. Units, persons who are re-admitted are

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[15] It is hard to believe this is a group comparable to our C.D.O.s but apparently it is. In Poland "a record is kept of those who cannot pay and measures are taken to secure payment at a later date" (28,p.145).

allowed to stay only up to 48 hours. The maximum stay in the Prague unit is 12 hours; in the Warsaw and other Polish units, 24 hours.

Treatment and Facilities

Because the main purpose of the Detoxication Centres is to deal with acute forms of alcoholism (with the exception of Baltimore, which also takes patients "who are chronic alcoholics desiring treatment"), the emphasis is on medical and nursing treatment for 'drying out'. The short stay also appears to militate against almost any other kind of treatment within that setting.

Two of the units, Baltimore and Washington, were opened in or on the grounds of a General Hospital. In Baltimore, the Alcoholic Detoxification Unit consists of a 5-bed ward set up in Provident Hospital with 5 'recovering alcoholics' as orderlies. In Washington a 25-bed centre was opened on the grounds of the District of Columbia General Hospital but was later moved to its own building, a permanent site in a high drunkenness arrest area, with 50 beds and later 75. The care given is essentially nursing care. The Director is a Registered Nurse with a staff of 29 full-time and 2 part-time nurses.

In St. Louis, St. Mary's Infirmary was turned into a 30-bed Detoxification Center using the existing facilities and nursing staff of 24. Also on the staff are two part-time physicians, senior medical students, a resident psychiatrist, and two social workers.

The Manhattan Bowery Project opened its 50-bed unit on the fourth floor of the New York City Men's Shelter with a nursing staff of 33. A physician is always on call and makes daily visits. The emphasis is strongly medical.

Toronto's 22-bed Detoxication Unit was opened in a building formerly used as an in-patient unit of the A.R.F. The staff consists of an internist part-time Clinical Director, 15 R.N.s,

19 male psychiatric attendants, final year medical students, and a social work staff of 4.

The 22-bed centre in Prague is housed in a larger psychiatric unit for in-patient care, with doctors, nurses and a social worker on staff. In fact, the anti-alcohol station is the first step in the alcoholism prevention program. Its purpose is to detect alcohol problems early on, as well as to provide medical treatment for acute alcoholic states. The Warsaw centre has a medical and nursing staff which caters to 150 patients.

In all 7 centres, upon admission the patients are bathed and bedded and given medication. In three (8,11,18) a complete physical examination is made. All units have access to a general hospital (and in the case of Toronto, to the Medical Unit of the A.R.F., where the seriously ill or unmanageable may be sent). Blood and urine analysis and X-rays are provided by St. Vincent's Hospital for the Manhattan Bowery patients. These analyses are done at the Centre in Toronto and the men are taken by taxi to the Medical Unit for X-rays.

St. Louis and Toronto attempt certain therapeutic measures during the recuperative period in the Detoxication Centre. St. Louis encourages 'task therapy' (housekeeping duties of the center) and A.A. participation. It provides didactic lectures and films as well as group therapy, and gives help with finding employment and housing.

The Manhattan Bowery Project and the A.R.F. Unit provide craft programs, and various recreational facilities including television and reading material. In Toronto there is considerable emphasis on the supportive role of the nursing staff.

Washington provides clothing and some funds and also uses A.A. programs.

All the detoxication centres have a referral service to deal with some aspect of post-detoxication. In fact, a referral

service has been built into the New York, Washington and Toronto programs as part of their experimental intent; in the case of New York, to see how the Bowery drunks would react to being referred to other agencies and in the case of the A.R.F. in Toronto, to see how the community agencies would react to being asked to deal with chronic drunks.

The Baltimore Detoxification Center concentrates on referral for assistance with alcohol problems to A.A., alcohol clinics and hospital out-patient clinics. The Czechoslavokian and Polish centres also refer for alcohol treatment.

The other centres attempt to use every community resource that exists for rehabilitation, and some have been successful in establishing a nucleus for effective referral.

St. Louis has established a good liaison with the alcoholism units of the Mental Health Center and State Hospital; the State Division of Welfare has assigned a worker "on call" to work immediately with patients eligible for assistance; and church, Salvation Army, a few community services, and the Employment Service all help or show a willingness to help.

In the Manhattan Bowery Project, on the third day when the patient is moved to the recuperative ward, he meets his caseworker, who discusses his aftercare. The most frequent referral programs used are the rehabilitation units or psychiatric wards of State hospitals, Camp LaGuardia (a residential camp of New York City Social Services), or the Project's aftercare clinic. A not unimportant aspect of the referral system is the provision of transportation by the street patrol to the particular community resource the patient has been referred to.

In Washington, patients may be referred for treatment to one of two Public Health outpatient facilities for alcoholics and to other hospitals for medical treatment. The number of referrals for social aid are much lower than medical referrals (1,724 as compared to 7,705). Various religious and community services are used but one of the most used and evidently most acceptable by the men is the Volunteers of America.

In Toronto, the A.R.F. Unit referred, during its first 6 months, approximately 27 per cent of its patients, and these mostly to agencies that treat alcoholism and problems associated with alcoholism, in particular the A.R.F. Out-Patient Clinics and Day Treatment Centres or Halfway House.

Results

Generally, the aims of the detoxication centres appear to be more modest or more defined than the other treatment modalities. This is partly because acute intoxication can be treated medically and quickly, whereas chronic alcoholism requires lengthy treatment of a diverse kind and neither the nature of the disease, if it is such, nor the treatment, is fully understood or agreed upon.

The efficacy of the detoxication units, then, is not to be assessed in terms of the quickness of the patient's recovery from his bout of intoxication or of his subsequent abstinence, but rather in terms of the stated purposes: to provide an alternative means of dealing with public drunkenness and to gain knowledge of community resources which might be of assistance to these men when they are released from the unit. Certainly all of the units provided the necessary medical and nursing care of the acutely ill patients brought in to them.

There appears to be no assessment in the literature of the results of the Detoxification Unit in Provident Hospital. However, since the stated aims were to treat alcoholism as well as intoxication, and since admission requires referral from outside sources, it seems likely that more chronic than acute cases would be admitted and few if any public drunkenness offenders. The results would probably not be very relevant to this study of chronic drunkenness offenders in any case.

The reports from St. Louis state that police time spent in handling public drunkenness cases has been reduced.[16] The amount

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[16] The arrest procedure of a public drunk in St.Louis is,however, particularly time-consuming, since it involves first taking the person to a general hospital, waiting while he is examined, and then booking him in at the police station.

claimed varies: one report (15) states a 50 per cent reduction from 95 minutes to 47, another (8) from 3 hours to 20-30 minutes. At any rate, the reduction appears to be substantial.

Also, the arrest and re-arrest figures have been considerably lowered. Number of arrests has decreased by as much as 60 per cent. Even including admissions to the Center, there is a 28 per cent decrease in police contacts (26). There is no suggestion, although it seems a distinct possibility, that this decrease is a function of a change in police attitudes and arrest behaviour.

Regarding the effect of the Center on drinking, it was found that 19 per cent of a 200-man sample were still abstinent 3 months after release (15).

The emphasis in the Manhattan Bowery Project was strongly medical and after a year's operation the need was felt for a broader range of medical services. Also, the capacity was limited to 10 admissions a day, so that the effect on the drunkenness arrests was negligible. For these reasons two other units, an out-patient clinic and an emergency care unit were created. With the setting up of the emergency clinic which could handle 200 men a week, Bowery arrests for public drunkenness and vagrancy dropped from 1,674 in a 3-month period in 1968 to 270 in the same period in the following year. Again we do not know if this indicates an actual change in the behaviour of the drunkenness offenders or just a change in police procedures.

An aim of the Project was to discover if the public intoxicant would accept referral to other programs. Sixty per cent of the patients did, in fact, accept referral to some kind of after-care program.

The first assessments of the Washington Unit were conservative: "the short term results are benevolent and seem beneficial to both patient and community."(25). However, the results were sufficiently encouraging on several levels that from a 25-bed unit within the hospital it relocated into its own building with 50 and later 75 beds. The police, the Courts, and the correctional

facilities have been relieved of much of the burden of dealing with chronic drunks. Other conclusions are that a public health service for acute intoxication is a feasible alternative to incarceration; that the Unit is successful as a referral agency, and that such a unit can be run with nursing staff only. The feeling was expressed that the Detoxification Center is not very successful in getting the patients to recognize their problems associated with drinking, nor in providing the psychological setting to encourage them to do something about their drinking, and that the Center is "inefficient as a link in the chain of treatment events leading to lower relapse rates." (5,p.6). Also, one could say it provides an alternative to jail since 72 per cent of the patients are repeaters.

A review of the functioning of the A.R.F.Detoxication Centre was made after 11 months' operation (18). With respect to testing community resources for referral it was found that the treatment and rehabilitative resources available, even for the 25 per cent of the men who might be able or willing to use them, are totally inadequate.

Regarding staff, the evidence suggests that a detoxication unit can be capably run by nursing staff and specially trained non-professional assistants. Since only 4.5 per cent of the 1,552 admissions required medical help beyond the needs of detoxication, and since physical examinations appear to be unnecessary and even useless, there is no need for medical staff except on a consultative or on-call basis.

The conclusion was also reached that "there is no indication that the Detoxication Centre has been of any significant value in relieving the C.D.O.'s lot". The Centre was not, however, set up for that purpose but as a pilot project to test facilities and resources and to provide a suitable place for chronic inebriates to 'dry out' without using the police cells, Courts, and jail.

Proposals and Recommendations

Most of the proposals in the literature were either suggested as actual plans for the Detoxication Units which were eventually established or arose from observations and evaluations made after these Units had been in operation for a year or two. Thus the proposals regarding auspices, admission procedures, treatment and referral techniques are substantially as described above. Some of the recommendations stemming from evaluations tend to be modifications or extensions of the existing systems.

One proposal, from Sweden (27) is the result of a 1963 Parliamentary order for a Government Commission to study "the criminalization of drunkenness and the methods of care and treatment of acutely intoxicated persons." The English proposal is part of an exhaustive report requested by the Home Office on existing facilities and recommendations for treatment for habitual drunkenness offenders.

Both St. Louis and Toronto suggest that the length of stay in the detoxication unit should be flexible, ranging from a few hours to two weeks, depending on the needs and circumstances. Both also suggest a single detoxication and diagnostic centre for the entire city, with 125 beds suggested as the suitable number for dealing with Toronto's C.D.O. population (the number of beds being based on average arrests on the busiest day of the week)and the amount of time required to achieve zero blood alcohol level The District of Columbia Center, on the other hand, suggests setting up more centres to allow patients to stay 3 to 5 days.

Toronto suggests the police are the best 'rescue agency' - at any rate for Toronto and cities where Skid Row is a less concentrated area than the Bowery in New York. Two other centres (5,14) also presumably consider the police as the agency to handle public intoxicants as both suggest a special training or orientation program for the police.

In order to empower the police to bring public inebriates to the unit and to protect both the police and the staff against any possibility of lawsuits for unlawful action (such as, for example, assault) two proposals (24,28) suggest that the detoxication procedures should have the force of statutory authority behind them.

The reports of the A.R.F. Task Force and the English Working Party both recommend that the law should not be changed regarding the status of public inebriates because there is not yet a long-term recuperation and rehabilitation program for the homeless Skid Row chronic drunkenness offender. The Swedish Commission, on the other hand, recommends immediate change in the law. Inebriates will still be arrested but instead of punishment will be given treatment, even though no detoxication clinics have come into existence and jails would have to continue to be used, presumably as temporary detoxication centres.

Two proposals (24,28) make it clear that detoxication units should be concerned only with chronic public inebriates, at any rate in the early stages of their use. The St. Louis report, on the other hand, although the Center accepted only police case inebriates during its first year, recommends that in future 'walk-ins' and referrals be accepted as well.

All of the proposals put forward suggestions to the effect that the detoxication centre is useful only as part of a larger scheme. Continuing and expanded efforts to strengthen aftercare services, more social workers, and better referral liaisons with more feedback from the various services, are all recommended in the St. Louis and Washington proposals. The latter also recommends that "Research should be conducted regarding the use of innovative procedures for the aftercare of alcoholics, to be operated in conjunction with a detoxification center" (5,II-144). The Swedish Commission "presupposes that the expansion of detoxification clinics will be coordinated with modernization and expansion of the out-patient care of alcoholics"(27,p.189). Toronto (24) suggests the establishment of a multiservice centre, where the

men could stay for two weeks. This Centre would be staffed by counsellors, who would be responsible for specific individuals during their entire stay. It would also have workers from the various community agencies in attendance. Together they would help the men find the services they need.

As a further part of a post-detoxication program, the Report suggests the establishment of small "self-help" units which are self-sufficient residences for those men who might be able to change their drinking patterns but need the support and companionship of their peer group.

One paper (20) has suggested that as the disease concept of alcoholism is accepted, treatment will more and more often begin in the general hospitals. The authors do not use the term 'detoxication unit' but they suggest that it is detoxication and the acute symptoms that should be dealt with in the hospital. Out-of-hospital treatment would follow, tailored to the patient's individual needs. Two of the proposals for detoxication units (24,28) recommend that the units be attached to, or established in conjunction with general hospitals, and indeed that in small centres arrangements should be made for detoxication within general hospitals.

Summary of Basic Ideas Behind Proposals

Following upon a general acceptance of alcoholism as a disease, public drunkenness is gradually being considered an offence which should not be punishable by law. Laws have already been passed, or are about to be passed, in England, Ontario, Sweden and elsewhere, which will ensure that the person found drunk in public is not "punished" but is, instead, "treated" for his intoxication. In some instances the laws are not yet being put into practice because there is no adequate treatment facility available. Although the American Psychiatric Association in 1965 called for the treatment of alcoholics in general hospitals, there has been no overall attempt to use them for detoxicating public drunks. Until recently the main 'sobering up' station has been

the jail.

Recommendations have varied from changing the law immediately, even though there are no adequate medical facilities for detoxication (28), to keeping present laws (24) until the efficacy of the detoxication centre has been established and other facilities developed. Without detoxication facilities but with legislation abolishing public drunkenness as a punishable offence, the problem for the public health authorities could be overwhelming(if the courts recognized public drunkenness as a public health problem before the public health authorities had done so).

Even with detoxication centres the danger is foreseen that the revolving door in the legal system will be replaced by one in the medical or public health system - and that it will be set in even faster motion.

For these reasons, most of the proposals suggest either that community resources for care, treatment, rehabilitation, be investigated through a referral service, or that special facilities be set up for persons released from the detoxication centre.

Presumably an underlying assumption of the proposals for detoxication units is that the general situation regarding arrests will show improvement. Another must be that the well-being of the target population will be maintained or bettered. Impressions gained in both Washington, D.C . and Toronto indicate the reverse to be true. In Washington, where inebriates are no longer arrested but taken to the Center, it was noted that frequently they are released from the Center only to be returned the next day. Some men have returned as many as 150 times (2). In Toronto, where the maximum number of arrests for one person was found to be 14 in 1961, it has been discovered that some men have had as many as 30 arrests since the Detoxication Unit has been opened. Moreover, the visible and anecdotal evidence suggests that the present use of the Detoxication Unit is actually detrimental to the well-being of the chronic drunkenness offender

population. This effect is complicated by the fact that only a fraction of the men arrested for drunkenness get to the detoxication centre. The others receive a suspended sentence which leaves them free to begin drinking again almost immediately, without the known beneficial effect on physical health of a period spent in jail. So far these are general impressions. A study is currently under way in Toronto to examine the extent to which the old legal revolving door system has been replaced by a public health one, and to examine the consequences of the new approach.

The detoxication centre is able to supply a safe, sanitary, humane alternative to the drunk tank. It does not appear to supply a suitable alternative to a jail sentence. It can deal with acute intoxication adequately and well. The problem is that we are here concerned with public intoxication, which is generally a symptom of much more than the immediate intoxicated state. It usually indicates chronic alcoholism, for which we have no systematically effective treatment; and it almost always indicates a particular social condition - that of being without family ties, job or a home - or the imminence of such a condition.

If we consider detoxication as the initial stage in a total integrated program in which post-detoxication is of equal importance, then the whole program, not just the detoxication centre, is seen as the alternative to the legal system of handling chronic and public inebriation.

OPINIONS OF MAGISTRATES, CHIEF CONSTABLES, AND C.D.O.s

Most of the treatment proposals reviewed above have been put forward by experts in the fields of alcoholism, criminology, psychiatry, and social work. We wished to learn the opinions on present treatment facilities in Ontario, and any proposals for treatment, that those persons most directly concerned with the disposition of the chronic drunkenness offender might have. To this end we canvassed the opinions of all Ontario Magistrates and Chief Constables about treatment programs for C.D.O.s; and during the course of our interviews with a sample group of incarcerated drunkenness offenders, elicited their opinions and suggestions on the same subject.

Questionnaires were sent to all the magistrates and chief constables in the 153 police jurisdictions, representing 40 towns and cities, in Ontario. Fifty-nine (38.5%) of 153 chief constables returned the questionnaires, and fifty-eight (58.5%) of the 99 magistrates.

From the 6 jurisdictions with a population of 100,000 or more, only one questionnaire was returned by a chief constable, whereas 17 magistrates from these jurisdictions returned questionnaires. This means that whereas the opinions and suggestions of police chiefs of large urban centres are significantly underrepresented, the opinions of magistrates from these centres are overrepresented. Similarly, chiefs of police of communities with ten to fifty thousand populations are significantly overrepresented, while the reverse is true of magistrates.

Our sample of chronic drunkenness offenders was a group of 227 subjects randomly selected from men incarcerated in the Toronto (Don) Jail for public drunkenness, who had at least 3 convictions during the past 12 months on the same charge.

The suggestions of all three groups have a fairly narrow range. On the whole they are based on the general feeling among all three that simple incarceration is no solution to the problem of the chronic drunkenness offender.

The Magistrates

The magistrates, who are the ones constantly faced with processing the chronic inebriates through the courts, tend to feel that chronic drunkenness is not a criminal problem. This is illustrated in the following statements:

> Generally speaking, I feel that the problem of the chronic drunkenness offender is a social problem that cannot be solved by processing the offender through the Courts.

> After almost eleven years as a Magistrate, I am satisfied beyond any doubt that chronic drunkenness offenders should not be brought before any Court exercising quasi-criminal jurisdiction.

Nor do they feel that the Alex. G. Brown Clinic, which is a custodial treatment clinic in Ontario to which the Magistrate can send volunteering drunkenness offenders as an alternative to jail, provides an answer for the C.D.O. They express the opinion that the Clinic is regarded as a holiday by the men and that only the very few who have the desire to submit to treatment will get any help from it. They feel that any existing facilities are inadequate.

> ...unless the Courts have the power to send the offender to an agency or place which has a reasonable chance of effecting a cure. The Courts now have that power, but the facilities for treatment of such individuals are limited.

One magistrate who considers it a social problem rather than a criminal one says:

> I would like to see represented in court, besides the Salvation Army, various welfare agencies of the community - Alcoholics Anonymous - Employment Agencies - [the] Medical Professions - so that the Court might refer the offender to one or other of these agencies for specific help.

Three (of the 59) suggested the establishment of halfway houses.

> Halfway Houses for those discharged without any proper environment to return to should be established and not only in the larger centres.

Most suggestions are for some form of long-term custodial care.

> I feel a specialized institution should be considered to which the hopeless cases should be sent; (a) where they could be restored to health; (b) where they could do useful work in a disciplined routine; (c) where they could receive treatment for their addiction; (d) where they could be released on a system of parole which if broken would bring them back.

From their experience of C.D.O.s in court, most feel that compulsory treatment is called for.

> The chronic 'drunk' should certainly be put in a position where he can be treated. I think that on a voluntary basis, this type of treatment would be of no use to [a] majority of chronic drunks.

Employment of some kind as part of the treatment is frequently suggested.

> If the person is recommended for further treatment, there should be a type of therapy, e.g. outside work, such as farm [work] so as to build him up physically, and after that proceed with the advanced type of treatment.

> Mental and physical diseases are treated at hospitals and it may be that institutions should be set up for alcoholics to which they could be sent to be released when they were thought to be cured. If this were done it would seem essential that during the treatment period the parties should be employed at constructive work and paid accordingly for this work. This would enable them to retain their self-respect and also a portion of their earnings would be available for maintenance of their dependents which in many cases are a public charge.

Lengthy and indeterminate sentences on custodial farms or work camps are advocated by 11 (18.6 per cent) of the magistrates.

> However, as for custodial institutions, I think we need an institution well removed from the urban area, to which the offender could be sent for an indefinite term, not exceeding two years, where he could learn a trade. When the offender is finally released from this institution, he would be on systematic parole or supervision.

and

> Indeterminate sentences to an institution such as a prison farm where they can get the alcohol out of their system for a considerable time and be physically and gainfully employed.

Sixteen of the magistrates (27.1%) had no suggestions to make regarding what should be done about the chronic drunkenness offender.

> I am at a complete and utter loss in regard to any suggestions for changing or improving the present system of dealing with chronic drunkenness offenders; they appear to be the flotsam and jetsam of human living and, like the poor, will always be with us.

Considerable pessimism is shown about the possibility of any successful treatment of these men who are seen as persons incapable of helping themselves and/or unwilling to help themselves to a normal kind of life.

> I think, philosophically speaking, it is inevitable in any society there will be a certain number of people who will never find a niche and who will perpetually be a burden to society....
>
> These drifters are constantly before the Courts....

Most magistrates state the belief that C.D.O.s are not criminals but alcoholics, and that alcoholism is a disease. Twenty-nine, (or one-half) of them recommend treatment of some kind, in clinics, custodial institutions or hospitals. From their own experience of having sent offenders to a short-term

custodial clinic (the A.G.Brown Memorial Clinic) without success, they seem to feel that for the hard-core or chronic drunkenness offenders long-term, active, comprehensive programs and control are necessary.

The Chief Constables

The perspective of the Chief Constables is concentrated on law enforcement and the process of dealing with the C.D.O.s by arrest. They too regard the present punitive actions as inappropriate and ineffective.

> Incarceration of a drunken person in the jails has never been the answer, and to my thinking it never will be. Chronic offenders are sick persons, not criminals.
>
> In my opinion the problem drinker should be treated as a sick person, not confined to a jail cell.

Like the Magistrates, many of the Chief Constables also feel that the short jail terms are not long enough for successful treatment.

> I am in accord with institutions for treatment of alcoholics if the inmates' stay could be extended.
>
> The law should be altered to give the chronic drunk a longer sentence in jail on the third offence, one long enough to give him the chance to get the clinical treatment already set up for him.

Forty-one per cent advocated special treatment for C.D.O.s - voluntary or compulsory - some specifying clinics, psychiatric treatment and all mentioning a lengthy term. Another 11 per cent specified treatment in work or prison camps, with emphasis on physical building-up, long-term stay and pay for work. One of these suggested (seemingly unfrivolously) supplying the inmates with unlimited supplies of cheap wine until they were satiated.

Many Chief Constables also have their doubts about the efficacy of treatment because of the character of the chronic offenders.

> Very few will avail themselves of treatment when it is offered.
>
> Most chronic drunkenness offenders have no desire to reform and refuse offered treatment.

These views of the chronic drunkenness offender have as their common basis the experience that this type does not seem to be amenable to a 'reasonable' approach, encouragement to reform, or punishment, since he lacks the desire to change. Calling him a 'sick person' amounts to the same thing. A 'sick' person, mentally or physically is acknowledged to be unable to help himself in our society and to need special attention in a situation beyond his control. This judgment carries with it, as well, the implication that, hopefully, specialized care can remove the cause of the disease. If it is a disease, their behaviour is understandable; if not, it is simply a weakness of character for which there is no cure or hope of cure. This latter view is acknowledge in many recommendations for treatment in the suggestion of long-term custodial care and the uselessness of voluntary clinical programs for this type of drinker.

The recommendations encompass the general view that the chronic drunkenness offender requires more intensive action than the present system allows and that the present system simply maintains the 'revolving door' pattern of life for this kind of person.

The Chronic Drunkenness Offenders

The C.D.O.s were asked about their contact with and opinions of specific institutions in Toronto: Alcoholics Anonymous, the Alex. G. Brown Memorial Clinic, a voluntary clinic, Brookside,[17] and the Salvation Army's Harbour Light. Their opinions and suggestions tend to run on the same lines as those of the Magistrates and Chief Constables, although they express some of their opinions more vehemently.

The chronic drunkenness offenders feel that on the whole they have been given little help with their problems, of which drinking is only one. Occasionally they single out a specific individual - a mission official, the rehabilitation officer at a clinic (who showed an interest and tried to help them in contrast to the relative disinterest of the total institution).

The treatment program with which C.D.O.s were most familiar was that of Alcoholics Anonymous probably because A.A. meetings are held within the Don Jail as well as outside. Their opinions tend to be split fairly evenly between favourable and unfavourable judgments.

The favourable comments often stressed the voluntary aspect of the program.

> They are a good organization. If you make up your mind, they will help you any way they can.
>
> It is a fine organization. One of the best. Their method is effective if a person really wants to quit drinking.
>
> I had a good opinion of A.A. ....They didn't condemn you, they didn't convert you, it was strictly up to yourself.

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[17] Brookside was the first A.R.F. Clinic and the one the men would have had most contact with. However, by the time of the study other A.R.F. clinics had been established, so that opinions may apply to them as well.

Presumably the experience of these men in A.A. groups was good - though not effective. Others found various faults with A.A.

> Well, it bored me. All it is, is that each man gets up and tells his problem, and I've heard this hundreds of times, and it gets monotonous. They're always talking about booze and it makes you thirsty. They've always got it on their mind.

> It takes a lot of will-power to hear all that talk about alcohol and stay dry.

The difference between the social position of the C.D.O.s and that of other members of A.A. was evidently keenly felt by these men.

> Felt I was slighted by some of the members, maybe on account of my clothes, I suppose.

> I was ashamed to go. I not well dressed. I not in my own country. I suppose they would help me, but I no feel comfortable.

> Seems as though every one of them who got up and talked had a business and lost it.

> They seemed to be too distant. I didn't know anyone there. If no one helps you directly it's tough.

Some of the C.D.O.s express the opinion that the A.A. philosophy is fine but that it is inadequate for men in their position.

> I think it's a sound philosophy except that a person should be established before they associate themselves with such a society. He should have a fairly good job, dress, a place to stay and so on.

> They try to help you quite a bit, but the trick is to have the means of support before you go. You can't expect them to support you.

In fact, the program is irrelevant to the chronic drunk as he now exists.

> Well, I thought it was very good. All the fellas were dressed nice and clean and they used to get up and tell us about their jobs and families and about how to quit, but it wouldn't fit into my picture. Well, them fellas are back with the wife and family and I couldn't go back.

Many of their replies show that the C.D.O. realizes a great part of the problem is having the motivation to be cured, but another is having support during the process.

It is interesting that of all forms of treatment, Alcoholics Anonymous has probably reached more C.D.O.s than any other single program, even though it has not (except perhaps very recently and in a few instances) attempted to gear itself to this particular group. For this reason it has had little success with the C.D.O. whose problem is, of course, much more than one of alcoholism.

Although the Alex. G. Brown Clinic may, as some magistrates feel, be considered simply a holiday by the drunkenness offenders sent there ("...it's more comfortable than jail," as one interviewee said) it does not follow that the C.D.O. approves of it or considers it beneficial. Some do:

> If ever a fella wanted really to stop drinking, there is everything in the world there.
>
> They were very good and they got me a job.
>
> Actually, I was quite impressed with their treatment and its effectiveness. Also, it is free and they make a little provision on your release and help out if you want to get on your feet.

However, in spite of a certain amount of aftercare in the form of financial assistance or help in finding a job or a room, the C.D.O. expresses the opinion that such help is not sufficient.

> They were very good [one admitted, but added:] had no luck getting a job, got despondent [and went back to drinking].

> ...not successful 'cause they put a man on the street with only [a] room.....When a man comes out he needs more than just money. Sitting in a lonely room with just money makes a man go out and get a drink.

> The Clinic was all right. Work afterwards was the problem.

Others were vociferous in their negative attitude towards the Clinic.

> I think it's useless, ... In fact I know it is.

> I didn't want no part of it. I didn't think I was an alcoholic.

> I don't think its any good at all. I've only known one guy who has come out of there and has quit.

Many found their experience in the Clinic disillusioning, probably because it neither cured them of drinking nor re-established them in society. Their criticism of post-release care indicates that they feel a person cannot be released from a total dependency situation and be expected to find his feet immediately.

The A.R.F. clinics are voluntary treatment centres for alcoholics with which only 10.7 per cent of the men interviewed had come into contact. (Brookside had been in operation approximately 13 years at the time of the study.) Opinions of it varied:

> It wasn't too good ... the percentage of successful people there is low because there isn't enough recreation, people sit around and have nothing to do.

and

> Far superior to A. G. Brown. The atmosphere for one thing. They showed us the effects of alcohol on the brain.

The Clinics, being voluntary, off Skid Row, and not geared to the needs of homeless, indigent, chronic drinks, are not likely to be highly successful as a treatment centre for C.D.O.s.

Only 20 per cent of the men interviewed had had contact with the Salvation Army Harbour Light Centre, which had been in operation at least 6 years at the time of this study. A few of these felt it was beneficial.

> There's another good chance for a fellow [who] wants to make a go of it.
>
> Very good home. They do utmost to help. Gave me two or three chances.

The reaction against the Harbour Light is based chiefly on a dislike of having to undergo a religious program.

> It's a fine place. You keep the company of other guys who are trying to keep sober. Of course, it's compulsory to go to Bible classes.
>
> It's pretty hard for a person of another faith to fall into their line of teaching.
>
> It's a good place: food was good, but too much religion - forced church services in the evening. You had to attend them or you were on the carpet.

Some expressed their opinions much more vociferously:

> There was more drinking going on there than any bar. There is no rest at all. I don't advocate it because of the religious pressure. I know why I wasn't allowed in for treatment - it was because I wouldn't be a hypocrite and give testimony.
>
> ....Attended meetings there just to get something to eat, but I never joined them. Fellows I know go into the Harbour Light and are still drinking, hiding it. That's what I call a hypocrite. Others just go in for the room and board... They're kidding them; I wouldn't stoop to that yet.

> It was horrible....It consisted of an hour's Bible study in the morning and an hour in the afternoon. The man who gave it - well, he had about sixth grade education for something nobody understands, and you scrubbed floors and that besides paying $12.00 a week for board.

> All in the same boat as any other mission. You have to be converted to get anything out of it. You've got to go up and be saved.

The interpretation the individual makes of his experience should be viewed with a certain amount of skepticism. Nevertheless, the preponderance of negative attitudes towards the Harbour Light is of significance, indicating that a standardized opinion of the Harbour Light, whether based on fact or fantasy, has evolved among this group. As with the A. G. Brown Clinic, it may represent a disillusionment stemming from their failure in a voluntary program, a disillusionment most often projected onto the institution. Whatever the rationale for it, the attitude is effective in controlling behaviour and forming opinion throughout the group. As one man who had never been in the Harbour Light said, "I've got a poor opinion of it based mainly on what guys have told me."

In order to find out if the C.D.O.s had any suggestions of their own as to treatment programs which they would consider suitable for chronic drunks, we asked them the following question:

> Suppose the authorities decided not to put men who get drunk in jail, what do you think they should do with them - if anything?

If an institution was suggested, they were asked, "What sort of people do you think should run it?"

One might expect recommendations evoked by these questions to be coloured by the desire for drunks to have a 'soft touch' which they could use while continuing their drinking. In fact, it seems to be about an even split between those who want to be less inconvenienced by the law and have some service which could be called a soft touch; and those who feel that complete instituionalization or extensive rehabilitation is necessary. It is difficult to assess these different positions since the "objective" level is a product of subjective interpretation. For example, what would

seem to most people an excessive kind of punishment by loss of liberty, may be considered a soft touch by this kind of offender.

Some of the men made an effort to answer the question and to think it out; others simply did not care or did not want to have to think about it. A number share the pessimism of the Magistrates and Chief Constables, as well as that of many researchers, concerning the possibility of rehabilitating this type of offender by any reasonable procedure, in view of the complete lack of potential which they feel they have.

Minimal suggestions were of this sort:

> Should be a place for guys looking for a place to roost, where they could earn their keep.
>
> Just a place where a guy can stay until he gets one pay and on his feet.
>
> A place without bars, make him feel at home and that someone's taking an interest in them. If the man admits he has a problem something should be done for them.
>
> They tell me that in Quebec if they see a man who's drunk they'll run him in 3 or 4 hours and then let him go. I think that's right. But what they'll do with the habitual guys, I don't know. I think they should put them to work, even the old guys. I know I can do some work. They sling the lead. If they put them to work they wouldn't come so bloody often.

Many look upon work as a kind of rehabilitative procedure, a therapy, rather than as punishment.

> For chronic alcoholics, they should get a chance at rehabilitation in some kind of set-up. It should include a job and a place to live.
>
> I think it'd be very good if they had a correction-house, where they'd be able to work and be able to rehabilitate themselves gradually. Not in one big group, but two or three at a time or else they'll start drinking again. I suggest clothing, shelter and work and also a little bit of finance. I don't mean under guard, but sort of open-house with certain senior officials and rules and regulations.
>
> Put them to work, bush work, someplace away from the city and away from the booze.

> Guys should get paid for their work.
>
> Try to get the person a new thought, or outlook on life, new values, but I don't know how it would be done.
>
> If a man has nothing, what good is it to preach to him or jail him? I think work is important. Maybe some institution where he could work.

There were very few suggestions for specific treatment, other than work. One person made this suggestion:

> There are all kinds of drinkers. Some just need financial and employment aid. Others definitely need psychiatric help.

Generally, the C.D.O.s suggest that, whatever the institution or project, it should be sponsored by the government.

> It could be a government-sponsored factory - but give them wages so that they could build up some kind of reserve.
>
> I don't see why they should put drunks in jail. They should have a farm or something and treat them. You can put these fellows in the open and they won't run away. The government could run it.
>
> Put them on a farm or factory where they could produce something for money or wages. Like this they don't make nothing; have nothing when they get out and end up right back in again.
>
> Government should build a factory or a farm on a paying basis, put drinks there, pay them a wage, save it while the man is there, so that when he gets out he should have enough to rent a room and for food while looking for a job, for approximately a week.
>
> A place such as a farm where they could go until they feel better. Should be able to get treatment if they can take it.
>
> Work is needed where you can put older men to work. Maybe some kind of government project.

The preoccupation with the need for money on release might be interpreted as looking for a 'soft touch'. On the other hand, being paid for work in whatever institution it is would be an important factor differentiating that institution from jail.

Physically also, the C.D.O.s feel the institution should not be like a prison with bars, guards, and strict regimentation. It should, however, be of a custodial nature. The term 'protective institution' might best describe what the men seem to suggest: a farm, a factory, a work project, sponsored by the government, which would include a place to live, under minimal supervision, and which would be, presumably, compulsory.

The emphasis on government-sponsored institutions and facilities is a logical consequence of their attitudes towards missions and other institutions with strong doctrinal or religious overtones.

Many C.D.O.s feel the persons running these institutions should be ex-drinkers or reformed alcoholics; others that they can be drinkers if moderate ones.

> First of all they should be people with an understanding of the problem. Secondly, they should have an inherent desire to help people.
>
> Too often people get this job - well, it's just a job to them and a pay cheque. An ideal man would be a man who had the problem himself and had got over it. They have a strong desire to help. I think the whole staff should be made up of this group.

All feel they should not be temperance people:

> People who can drink but not to excess. They would not be altogether teetotalers or temperance people. If temperance people were in charge, it would work out differently. Too much contempt would be shown by the staff to the inmates wouldn't be able to help the people.

The suggestions of the C.D.O.s are not far removed from those of the Magistrates and Chief Constables and even some researchers, though by no means as comprehensive. The Magistrates and Chief Constables tend to emphasize the alcoholism aspect of the problem - understandably since it is because these men are drunk that they are arrested and appear in court. Many C.D.O.s refuse to see themselves as alcoholics. Although they realize drinking is a problem, there is an underlying feeling that it is not the biggest and certainly not their only problem. They seem to recognize their need for security, companionship and employment free from temptation to drink.

Reclamation of the hard-core chronic drunkenness offender may not be possible, as many persons who have had dealings with them are convinced. But if it is to take place, or even to be attempted, the C.D.O.s suggestions should not be overlooked: not because they present solutions but because the solutions they present indicate some of the reasons treatment has failed so far. What they seek is a lengthy period in an environment removed from a society in which they have only a degraded place; where they will be allowed to recover some sense of dignity and their own worth.

DISCUSSION

Of the various forms of treatment facilities available to the chronic drunkenness offender, there appears to be no single one which is outstandingly better or more successful than another and none which can be recommended as an examplar by itself. This may be due to lack of valid and reliable evaluative studies on most of them and widely differing criteria of success. A few, such as the Court Honor Classes which operate exclusively for the C.D.O., have had conspicuous success in apparently helping to lower the rate of drunkenness arrests in their area of operation. The success of these appears to depend a great deal on the personality of the judge involved, and also on the facilities in the community. On the whole, the evidence indicates that only a complex of facilities and approaches can cope adequately with the problems and treatment of the chronic drunk.

The reasons are twofold. Firstly, the needs, the problems, and the motivations of the C.D.O.s differ because they are at different stages in the C.D.O. career. For example, some of them - probably more recent recruits to this way of life - may still be living with their families, even holding down permanent jobs; for them outpatient treatment might prove most suitable and satisfactory. Whereas for those persons without the responsibilities or demands of home or job, in-patient treatment might be best.

Secondly, during the course of treatment, the patient's needs change. Initially, emphasis would probably be on his medical, psychotherapeutic, and job training needs. These would change over time to broader social needs and 'after-care' treatment or support.

A most important aspect which must be considered when establishing a facility or facilities for the care and treatment of the chronic drunkenness offender is how and whether the C.D.O. is motivated to use whatever the facility may be. The C.D.O.'s

own motivation is weak: he has been a heavy drinker for a long time; any treatment he has tried heretofore has not worked. Although he may not like his way of life, he does not necessarily recognize the extent to which is contributes to that way of life; his only friends at present all drink and if he stopped he would have no friends at all. He is at a stage where he has nothing to lose by going on drinking.[18] Therefore the push must come from somewhere other than in himself.[19] Motivation can come either from the facility itself (as in the reaching out method used at the South End Center for Alcoholics in Boston (1) or it can come from the outside (as where treatment is a requisite of court probation). It can be voluntary (like the Salvation Army Alcoholism Rehabilitation Clinic) or compulsory (custodial treatment programs).

The term 'treatment' implies an acceptance of the illness theory of alcoholism and a shift to considering chronic drunkenness offenders as patients rather than primarily as offenders against the law.

Here perhaps is a cause of the confusion and lack of success in dealing with chronic drunkenness offenders. On one side is the medical profession, which finds it difficult to play the role of healer successfully when it does not have an effective treatment for alcoholism. On the other side is the C.D.O. as patient who, if we accept Talcott Parsons' 'sick role' model(10)does not behave as a patient should. The sick person seeks help from the doctor. If he is pronounced ill, he is given special care and allowed certain privileges such as not having to work, being looked after, given appropriate medicine and other treatment. The

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[18] This applies only to those C.D.O.s who are on Skid Row.

[19] Motivation to seek treatment is somwhat different again from reluctance to accept proferred treatment. C.D.O.s are considered to be especially reluctant to accept treatment, or 'recalcitrant' to treatment (4,5,9). The implication that this reluctance is peculiar to the C.D.O. seems unfair. Many a 'normal' person puts off going to the doctor or dentist even when he knows something is the matter. The C.D.O. may or may not feel there is something the matter with him. If he doesn't (if he does not think he is an alcoholic, for example) then his reluctance is even more understandable and certainly must be taken into account when motivation is considered.

underlying assumption is that the patient will make an effort to get better, that he will respond to the treatment given and eventually resume his normal functions. If he does not show this progress, after a certain time, he is accused of malingering.

The C.D.O. does not play this role very well. To begin with, he seldom asks for help from the medical profession. He does not appear to feel he is sick (except when in withdrawal). If he does find himself in treatment, he may respond well, accepting the full term, and remaining sober during that period. His obligation to get better ends there: his attempts are strictly temporary and he is likely to return again and again to the same treatment facility if it is available to him. This tends to cause a demoralization of the staff of the facility and probably of the patient, neither of whom see the treatment they are giving or being given as having much effect. The usual result is that the chronic drunkenness offender will eventually be excluded from further treatment.

If the law considers chronic public drunkenness offenders to be ill rather than criminal, then jail treatment programs become irrelevant to this population, who will no longer be incarcerated (at any rate for this particular offence). Such a change of law would eliminate court probation, court referral, and court "classes" as well as jail programs. It would also eliminate a very effective (in this situation) motivating force: coercion. A new law for persons appearing drunk in public would probably not only require them to be taken to a detoxication centre for a short period, but it might also prescribe treatment. Could it prescribe enforced treatment of a certain duration? The ideological implications make it dubious. It can be argued that chronic alcoholics should be forced into treatment as public health hazards - as are persons with tuberculosis. The cases are not strictly parallel, however, since tuberculosis is a communicable disease, and alcoholism is not. If the law

does make treatment compulsory,[20] the facility will not have to be concerned with initial motivation for entering treatment. Otherwise it will need to be built into the program.

The present facilities for treating the sick - the general hospital, the mental hospital, the alcoholism clinc - have all been used at some time by chronic drunkenness offenders, but with very limited success. The general hospital is not set up to treat their chronic alcoholism but only the immediate consequences of their drinking, such as alcohol poisoning or severe withdrawal symptoms, particularly delirium tremens. Mental hospitals have offered little treatment beyond abstention. The very fact of commitment by relatives, or even self-commitment, limits the number entering mental hospitals among these persons who so frequently have become lost to relatives and lack the motivation to commit themselves, especially to an institution for the mentally ill. (Even if they see themselves as alcoholics they certainly do not see themselves as insane.) Moreover, chronic drunkenness offenders are not psychotic *per se*. Their excessive drinking was originally, in all likelihood, a behaviour symptom of an underlying, different problem, but over time their drinking has become an autonomous problem with its own symptoms.

The alcoholism clinic has also had little effect on the chronic drunkenness offender population. As always, lack of motivation (i.e. family or other referral and unawareness of their problem) has prevented any significant number from seeking help from such clinics. Further than that, attitude of clinic staff who know the C.D.O.s are recidivists, who may believe them to be untreatable, who feel it is only sensible to spend their energies on more hopeful cases, has prevented acceptance of C.D.O.s as patients.

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[20] The Swedish proposal (15) specifically recommends that punishment for drunkenness be abolished but that arrest for drunkenness be continued with compulsory rehabilitative measures.

Should C.D.O.s be treated as alcoholics or as a special group of patients with a differing type of illness (C.D.O.-ism?)? If we take into account the whole social configuration of the C.D.O., then he is seen to be not simply an alcoholic. He is a homeless, usually indigent, deprived, derelict alcoholic who has spent a great deal of his life in jail.[21] Not only the motivation for treatment but the aim of treatment must be conceived of differently for the C.D.O. than for the non-C.D.O. alcoholic. The aim of treatment for the non-C.D.O. alcoholic is to cure him of his addiction so that he can function satisfactorily in the social and economic areas. The aim of treatment for the C.D.O. is to reinstate him in a society to which he has become completely alienated. This ambitious, encompassing aim will surely require 'total treatment'. Unlike the upper or middle-class alcoholic, the C.D.O. (who, in the unlikely event that he came originally from these classes, can no longer be said to belong there) does not have a family or job to return to, or if he has, he has reached a stage where he is apparently unable to do so by his own efforts. Thus sobriety or ability to deal with his drinking problem becomes only a small part of the treatment aim which also includes removing him from a Skid Row way of life, educating him (vocationally, socially) and supporting him over a kind of prolonged social crisis.

Earl Rubington's scheme (13) described above is not to remove chronic drunks from Skid Row but rather to improve their image and raise the moral level on Skid Row by helping to prevent fights and misbehaviour and in general relieve the police and Courts of a problem they do not want. This scheme would be workable within present laws. It is not concerned with rehabilitation of C.D.O.s except for those who are taken into the Unit, but of allowing them to remain on a more orderly Skid Row with a less degraded self-image. The justification for such a scheme

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[21] This definition will gradually change with a changing law. In fact, there will no longer be C.D.O.s. It is interesting to speculate how this in itself will change the C.D.O.'s image of himself and perhaps hasten the dissolution of C.D.O.-ism, a kind of reverse of the self-fulfilling prophecy.

would seem to be a commitment to a laissez-faire attitude and a belief that Skid Row, albeit in a modified form, serves a worthwhile purpose. For those who believe that many C.D.O.s have considerable rehabilitative potential (which a Skid Row type of existence frustrates) even when the degrading experience of constant arrests and jailing is removed, such an aim is too limited and tangential.

Although such a scheme would do away with the revolving door aspect of their existence for a great many C.D.O.s, it would also do away with the recuperative period in their lives which jail now provides. With no substitute for this convalescent characteristic of imprisonment beyond the amenities of Skid Row, the C.D.O.s' physical deterioration would undoubtedly be both more rapid and more extensive (see Discussion - Chapter XII, Physical Health). The extra time 'outside' would allow for more constant drinking with its consequences of malnutrition, increased exposure (to the elements), deteriorated person appearance, and so on, which occur when the C.D.O.s go on a spree. The whole downward-spiralling trend would actually be accelerated, even though the C.D.O.s would presumably be picked up fairly early in their spree by the Control Unit and allowed to 'dry out' in the Centre or in hospital. The length of each period so spent would be much shorter than the average jail sentences they receive at present, since the purpose of the Centre is to provide overnight sleeping accommodation only.

Thus, although the overall moral standards and even the appearance of the Skid Row area would be improved by the use of a Control Unit (a primary aim of the scheme) there seems no reason to expect it to reduce chronic drunkenness. In fact, it would probably have much the same effect on the physical appearance and health of the men, and on public drunkenness in general, as the detoxication unit.

There are numerous factors one can pick out which suggest reasons for failure of treatment of the chronic drunkenness offenders, provided by the various types of facilities.

Selective processing or screening which has been used in almost all treatment programs, although it might raise the chances of successful treatment of those C.D.O.s selected, lowers the overall number, since so few C.D.O.s are likely to be selected for treatment. This is particularly true where the criterion of success is abstinence. For example, Mills and Hetrick (9) point out that one of the factors on which the success of the Municipal Court Program in Cincinnati depends is the Court Clinic's careful screening to select those men who seem potentially responsive to the program. Selection is often based on such characteristics as few prior drunk arrests, age under 40, living with family, and working, since these suggest good prognosis. This selection, of course, excludes the majority of chronic drunkenness offenders. Those programs that are not selective regarding age and social stability are usually the compulsory jail programs (such as that in Saugus (11)) where only those individuals with whom it is completely impossible to communicate are excluded. Moreover, the program is set up specifically for offenders accused of drunkenness, almost all being chronic cases.

The idea heretofore has been for the C.D.O. to fit into a program (established on the basis of preconceived notions) or not to enter it. Gerard and Saenger, in their book Out-Patient Treatment of Alcoholism (6), make the interesting and seemingly revolutionary suggestion of "...preferential admission for patients who are impaired in social stability, so that they, and their needs would set the tone of the institution, rather than play a role in which they are tolerated..."(p.203). They are suggesting the socially impaired person is a different kind of patient with his own peculiar needs. Although the socially impaired alcoholic is not necessarily a chronic drunkenness offender, the opposite usually pertains. This recognition of special needs partly accounts for the relative success of the Court Honor Classes which exist specifically for C.D.O.s. Matters of direct application to the C.D.O.s' needs, discussions of his immediate problems, as well as his relationship to alcohol, are taken up at these classes.

Another factor which mitigates against success is short duration of treatment. Lawrence Katz, in describing the Alcoholic Rehabilitation Project of a Salvation Army Men's Social Service Center, says that "The length of time a man remained in the rehabilitation program....was an extremely important variable." (8, p.44). One variable for a good prognosis was a stay of over three months in their residential program. Gerard and Saenger suggest that treatment as in-patients should be 3 to 6 months at the minimum. This becomes a factor against the success of a jail program, as those responsible for the Alcoholism Project at Saugus (11) recognized. The men are in for only short sentences, so that the goal is more to "stimulate motivation for treatment after release from Saugus" (p.13) than to offer extensive treatment in the jail. The project provides more for counselling with an emphasis on preparation for entering group therapy. Unfortunately this preparation for treatment on release is somewhat negated, since we are told that the community resources are at present few in number or not relevant.

This suggests another factor which is pivotal to successful treatment of chronic drunkenness offenders. On the premise that treatment needs are various over time, continuity of treatment becomes essential. A corollary aspect is the very important one of coordinating the various types of programs, particularly with respect to phasing or progression.

Very few facilities carry on the treatment beyond that offered within their own walls. Some are set up for 'treatment," some for 'aftercare' but they are usually separate and distinct entities with their own separate staffs. An effort to provide some continuity has been made in the Municipal Court Program in Cincinnati, where the psychiatrist, who is director of the Municipal Court Clinic, also heads the Alcoholism Clinic at the general hospital. The program involves attendance at the Alcoholism Clinic as a stipulation of probation. The probation officer is a psychiatric caseworker who not only makes recommendations to the Court as to suitable referrals, but he keeps in touch with the

the patient's progress at the Clinic and may do casework therapy with wives, and helps the patient with practical matters.

This illustrates a certain continuity, up to a point, but no mention is made of any further facilities, such as halfway houses, to carry on treatment of a different nature.

From perusal of facilities, their success and failures, there is every indication that treatment of C.D.O.s must be extended over a variety of facilities for different stages of treatment; for example, detoxication, medical treatment, psychotherapy or group therapy possibly, occupational training, job and residential placement, social assistance, out-patient treatment and support.

With individuals as poorly motivated as chronic drunkenness offenders undoubtedly are, linkage between the various facilities, presuming them to exist, is most important. This means physical transportation from where a C.D.O., picked up for drunkenness, is allowed to dry out (say in a detoxication centre) to the initial treatment centre where he will receive medical treatment and medication to help him over the difficult period of withdrawal, together with some form of counselling. At this or another centre, he might receive job training. As he becomes ready to leave this hospital or clinic he needs help in finding a job and suitable accommodation. It may be a halfway house or lodgings, or a permanent rest home. But not only does he need help in locating these, he needs help in getting there. He is not 'cured' on leaving the clinic; he is presumably merely ready for the next stage in his recovery. It is very easy for him not to get to that stage. Edward Blacker (1) describes a program in Boston, the South End Center for Alcoholism, which is an agency whose specific aim is to "specialize in the linkage role". The staff would literally transport the C.D.O. from one facility to the next and then attempt to maintain contact with him in order to provide continuity.

A possible objection to this system is that it will degenerate merely into a free taxi service. This is still valuable but not sufficiently so to take up the time of professional workers.

It seems feasible to us to use lay workers, possibly rehabilitated C.D.O.s, to undertake this task.

However, if continuity is really important for the successful outcome of treatment of C.D.O.s, then not only should treatment be continuous but so should the personnel. Instead of psychiatrists, social workers and so on being attached to a certain alcoholism clinic or a certain after-care program, they should be attached to certain chronic drunkenness offenders. A team of professional or lay workers should take the patient over from the time he is ready to leave the detoxication centre, follow him through whichever treatment program they feel to be most suitable for him, decide which type of accommodation suits this particular person, attempt to place him in a job, arrange for out-patient treatment or further therapy, suggest social activities and/or A.A. and take him to them if necessary. In short, the patient would receive constant guidance and support from persons he comes to know and trust and who know and understand him and accept him.

Regarding the treatment role of the halfway house, it too should not be expected to function as a complete treatment centre. It should be used halfway along on the treatment course, halfway between a dependent parasitic life and an independent, productive life in society, between intensive and comprehensive in-patient therapy and supportive out-patient therapy - a semi-protective situation.

It would also be wise to use a halfway house whose only members are Skid Row C.D.O.s, for the same reason that any aspect of treatment should be specific to this group. The rationale for this is pointed up in an article on halfway houses by Sidney Cahn:

> A study made by two sociologists on the Stanford team of five halfway houses, seemed to indicate that residents in halfway houses are similar in social class characteristics to the managers. Inasmuch as just about all the managers are former problem drinkers, they would tend to equate possibilities for recovery with certain social and psychological qualities which they themselves possess. All [managers] agree that lower class and Skid Row characteristics spell inevitable failure. (3, p.18)

If Skid Row alcoholics are mixed with other types, the standards and expectations are not going to be those suitable to the C.D.O.s but those from the higher class or status group. This will once again place the C.D.O.s in the outcast group for the many months or years which they might spend in the halfway house. Also, because the number of members of a halfway house should ideally be no more than 20 (12, p.67), there would probably be too few C.D.O.s to evolve their own social system with its intrinsic unique rewards and satisfactions.

Whatever the treatment offered in the halfway house - A.A. meetings, group therapy, structured discussions - it should be suitable to the C.D.O.

The Type of Treatment

The C.D.O.s' special needs point to several factors necessary to get the men to participate in the treatment program. Residential or in-treatment is an essential for those men lacking a stable residence, unemployed, and without stable social relations. Otherwise, their homelessness might remove them from the immediate area of the treatment centre, which would lessen both their will and their ability to get there; seasonal work could remove them from the city altogether and casual work enhance an unstable life style; even if they have a place to live, without a family or other stable social affiliations to provide motivation, they are not likely to attend the treatment centre. "....for the patient who lacks the structuring influence of marriage, regular employment and familial residence, a preliminary in-patient experience of a special type might provide the basis for continued out-patient treatment which would be demonstrably relevant to change in his functioning (6, p.202).

The success (in terms of both attendance and reduction of drunkenness arrests) of the Court Honor Classes of Judge Harrison in Des Moines (7) and Judge William Burnett in Denver (2) illustrates the importance of the group in the C.D.O's treatment [22] and

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[22] It also probably illustrates the extreme rarity in public offices of persons with the wisdom, understanding and forbearance which these two men must have.

furthermore, of group treatment with his peers - that is, specifically with other chronic drunkenness offenders. (A.A., otherwise surely one of the most successful of alcoholism treatment modes, appears to have noticeably fallen short of success with C.D.O.s). It is as sensible to expect a well-educated, upper class professional or business man, who is an alcoholic, to respond to treatment that is directed at the Skid Row alcoholic as it is to expect the reverse to occur. Unless he is part of a larger group of chronic drunks, the C.D.O. will expect, not without reason, to be rejected by any other group. (He knows that even other prisoners in jail, up for much more serious charges than drunkenness, look down on him as a 'wino'. This he is able to support in jail where he can remain within his own group and even attain status in that group)(see Ch.VI, The Jail).

Several authors (8, 9, 16) have pointed out that group psychotherapy is the most effective for these men. Mills and Hetrick state that group treatment is used at their Clinic because "many court referrals cannot tolerate the intensity of the 50 minute face-to-face psychiatric contact" (p.57). Katz points out the importance of "...the formation of a sense of group identity and new interpersonal relationships; and the control and support provided in forming a relationship with an institution" (p.78).

In his Progress Report on the Alcoholism Rehabilitation Project at Saugus in California, Pitchess also makes the point that the men "...seem to welcome a feeling of organization and secure structure, particularly a social setting with which they are familiar" (p.4-5). This last is an interesting point. Within the jail setting (presuming the Don Jail to be typical of others which house drunkenness offenders) the C.D.O. is part of an established social system which functions comfortably within the larger organization of the jail. In that system they know security, they have roles and responsibilities, are aware of limits, and live and work extremely well. In such an atmosphere, where they feel comfortable, non-threatened and productive, they might better be able to accept and encompass the addition of a

counselling-therapy program. Therefore, in whatever facility therapy is given, it might be wise to allow time for and to encourage some kind of social structure to develop.

We might just point out the kind of group therapy which various authors have felt to be most successful with chronic drunkenness offenders.[23]

Because much of the C.D.O.'s problem is a social one, successful therapy appears to involve focussing on concrete situational and behavioural areas rather than the highly abstract in-depth psychiatric treatment. Even the non-directive type of group therapy is inadequate with this group, who react better to a very directed, led discussion. At the Saugus jail program, the groups are conducted almost like a classroom with the leader as the 'teacher' and much of the content is informative. Subjects range from drinking with its problems to job opportunities, and frequently members from the community have been brought in to discuss 'a considerable range of useful information'. At the much more informal Court Class, Judge Burnett says ".... we talk about sobriety and some of the practical problems in achieving sobriety" (2, p.11).

Employment is generally agreed to be an essential part of the drunkenness offender's rehabilitation and therefore most programs make an attempt at job placement. Considering the type of person they are trying to find jobs for - persons who have been jailed more than once for drunkenness and who tend to fall in the semi- and unskilled labour categories - this cannot be an easy task, particularly in times of high unemployment. A few programs offer vocational training, sometimes with an eye to the needs of the area in which the centre is located. Lawrence Katz reports (8) of the Salvation Army Men's Social Service Center, which includes workshops and full-time work for the residents of

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[23] Whether it was successful in itself or in comparison to other treatment modalities or no treatment has not been established.

the Center "Vocational guidance is particularly useful in helping the men to achieve a stable and productive work adjustment on the outside."

That working is important to our sample group of chronic drunkenness offenders is evidenced in their stated willingness to work in a treatment setting. This is not an unrealistic pose since the C.D.O. knows he can work and, in the jail setting, finds it satisfying and rewarding. In our society, working is the accepted norm of behaviour which is rewarded with money and by a place in society. The chronic offender's expressed desire to work may then be his bid to re-enter society as a normal or non-deviant human being. The sceptical attitude is that he wants the work for the money that would enable him to go on drinking. The C.D.O. appears to recognize - even fear - the partial truth of such an assumption and hence his wish - again frequently expressed - to live and work in a place run by the government under the supervision of individuals who would recognize his needs and problems and help him with them.

Personnel

Not much has been written about the personnel of the various treatment facilities, perhaps because often the authors are the personnel. Obviously special skills and attitudes are required of those dealing with chronic drunkenness offenders which differ from the skills and attitudes of those in comparable positions dealing with other groups. For instance, the therapist must be capable of taking a very active part in the group therapy sessions (and, if individual therapy is used, there, too). As Mills and Hetrick point out, "...the effective treatment of alcoholics, particularly of lower-class origin, is characterized by the greater demand placed on the therapist for activity and advice-giving. The therapists must show their support and help concretely" (9, p.56). They must also be flexible and accepting enough of the C.D.O.s not to expect them to conform to their own (probably) middle-class standards. Gerard and Saenger sum this up very ably: "Such a program....would require the development of a staff capable of accepting men and women of prolonged deviant

life-styles, and/or lower social class origins. The buildings, furnishings, clothing, language, and food should reflect such acceptance. The imposition of conventional middle class aseptic, clinical expectations, roles and relationships would undermine the possibility of helping these patients." (6, p.204).

Another interesting point about personnel which has been stressed in certain areas, is the use of recovered alcoholics or rehabilitated C.D.O.s. Two judges, in discussing Court Classes, recommend the use of recovered alcoholics:

> It doesn't take an alcoholic judge to organize a court class, but it does take a recovered alcoholic and preferably one from AA, who can talk their language....one who isn't far away from the pit of despair that these fellows are all in. (13, p.48)

> Any judge, wishing to start this type of program, would be well advised to enlist at least two alcoholics who have sustained recovery through Alcoholics Anonymous and who are dedicated to help organize and sponsor the group. (2, p.11)

Rather than using recovered A.A. alcoholics, Rubington suggests that his Control Unit, which would patrol Skid Row, should be made up of C.D.O.s who had become sober. He feels that "...alcoholics can rehabilitate themselves when they are paid to keep the Skid Row peace." (13, p.531). Using homeless alcoholics to 'rescue' others even less fortunate would have other advantages. Obviously it would release the police for other duties. Probably the drunks would be treated more considerately, or at least with more understanding, by former Skid Row drunks; and they would have before them the example of others formerly in their position who had attained sobriety and were doing a responsible job. At any rate, the rehabilitated C.D.O.s would know the area, understand the men, and not feel repugnance for either, which outsiders, whether police, social workers or volunteers might feel.[24]

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[24] This suggestion may be difficult to realize, however, since many Skid Row alcoholics or recovered Skid Row alcoholics have emphasized to this writer the absolute necessity of staying apart from Skid Row and its inhabitants if they are to 'go straight' or stay straight.

If a team, such as we hypothesized, took over and worked with the chronic drunkenness offender from the time of leaving the detoxication centre, it would undoubtedly benefit from having a 'recovered' C.D.O. as an additional member. He could act as adviser to the professional members, as an interpreter between them and the patient, and as a moral support to the C.D.O. The gain to himself would also be great: knowledge, self-respect, money. But in this situation the stress is on the value to the liaison between the members of the triangle: the recovered C.D.O., the C.D.O. patient, and the therapists.

Because terminology can shape our attitudes, it would be well to drop the term 'aftercare' from any discussion of C.D.O. treatment since it implies a cure followed by minimal supportive treatment. The emphasis will then be on improvement and movement in treatment rather than on cure. Those working with the C.D.O.s will be spared the disillusionment that comes with repeated failures.

APPENDIX I

BON ACCORD FARM

Among the spectrum of specialized treatment programs for chronic drunkenness offenders recommended by the Task Force of the Addictions Research Foundation were a detoxication unit, a rehabilitation farm, and a halfway house.

The Foundation took concrete steps in implementing the proposals on a limited and trial basis. As a result, a 200-acre farm with house and outbuildings was purchased in 1966 near Elora, Ontario, as the site of an experimental rural rehabilitation program for Skid Row alcoholics.

Neither traditional psychotherapy nor counselling is used. The objective of the program is to create an environment in which the behaviour of Skid Row problem drinkers can be modified along planned lines, with the use of programmed contingencies and reinforcers. Two tenets basic to this aim are that all behaviour is learned, and that 'deteriorated' Skid Row alcoholics have sufficient capacity for non-deviant behaviour to re-enter the mainstream of the larger society.

Applicants for membership to Bon Accord must be Skid Row, disaffiliated, economically dependent men, who have been frequently drunk in public. Upon admission the applicant goes through a two-week trial period, after which he must be approved by the Admissions Committee, composed of both residents and staff, who have one vote each.

If the man is accepted into membership he enters the formal phasing system. This is a set of arrangements of three phases, allowing for an orderly progression of behaviour norms and a scheduling of graded reinforcements. Specific standards and norms are established for each phase with respect to work production and skill level, use of drugs (including alcohol), social responsibilities, participation in community government, and performance of community roles. Accompanying these norms is a

graded schedule of positive reinforcers including wages and fines, various amounts of leave, varying qualities of living arrangements, and access to community services.

An Evaluation Committee (of members and staff) assesses each member's behaviour every month to determine whether he shall be promoted to the next phase, remain where he is, or even be demoted to a previous one.

Since no halfway house program compatible with the concepts and procedures of Bon Accord is available, two further phases were introduced to provide for the transitional needs. Phase IV involves living at the Farm and working (or attending school) in the larger community, or living outside but working at Bon Accord. In both instances, the members in this phase are expected to continue an involvement in the Bon Accord community, along with increased involvement in the larger community.

Phase V allows graduates of Bon Accord to continue involvement in its program in some leadership role.

From February 1, 1967 to May 31, 1969 (when capacity was 10) there were 55 residents who stayed an average of 113.4 days. When Phase IV and V were added, the maximum number of residents rose to 24.

A total evaluation of all aspects of the Bon Accord program from data gathered over a 5-year period is at present under way. An interim report, Bon Accord Milieu Therapy for Public Inebriates, was published as a substudy by the Addiction Research Foundation in 1969.

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